



# SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE

City of Rancho Cucamonga-  
Council Chambers  
10500 Civic Center Drive  
Rancho Cucamonga, CA 91730



**January 21, 2010  
9:00 a.m.**

## A G E N D A

### I. CALL TO ORDER

### II. APPROVAL OF MINUTES

– November 19, 2009

### III. SPECIAL PRESENTATION

#### State EMS Authority Achievement Award

Recipient – John Commander, San Bernardino County Fire Department

### IV. ICEMA UPDATE

- A. EMS MISS Status Report
- B. Status – Trauma System Assessment
- C. Implementation of Upland Air Ambulance
- D. Request for Proposal – Air Ambulance EOA

**INFO/ACTION**

### V. ICEMA MEDICAL DIRECTOR

**INFO/ACTION**

### VI. STANDING EMS SYSTEM MANAGEMENT REPORTS

- A. Trauma System Report (Quarterly)
- B. Base Hospital Statistics (Quarterly)
- C. ePCR Submittals (Monthly)
- D. Hospital Bed Delay Report (Monthly)
- E. Medication, Procedures, and Type of Patient Summary Reports
- F. Reddinet Assessment Reports – ILI Hospital Assessment Poll  
(Updated frequently during flu season)

([www.icema.net](http://www.icema.net))  
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### VII. OLD BUSINESS

- A. EMCC Memberships
- B. PBC Trust Fund Utilization

**INFO/ACTION**

### VIII. NEW BUSINESS

- A. Protocols
  - 1. Reference # 1050 MICN Certification
  - 2. Reference # 6070 STEMI Receiving Center
  - 3. Reference # 7010 BLS/ALS Drug and Equipment List
  - 4. Reference # 7020 EMS Air Drug and Equipment List
  - 5. Reference # 9120 Nausea and Vomiting (Zofran)
  - 6. Reference #10100 12 lead ECG

**INFO/ACTION**

- B. Election of Officers
- C. Annual EMCC Report

**IX. COMMITTEE/TASK FORCE REPORTS**

**X. OTHER/PUBLIC COMMENT**

**XI. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING**

**XII. NEXT MEETING DATE AND LOCATION**

**March 18, 2010**

**Rancho Cucamonga Counsel Chambers**

**10500 Civic Center Drive**

**Rancho Cucamonga, CA 91730**

**XII. ADJOURNMENT**

*The San Bernardino County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and office is located at 515 North Arrowhead Avenue, San Bernardino, CA.*



# SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



Richard Sewell Training Center  
2824 East W Street Building 302  
San Bernardino, CA 92408

November 19, 2009

COMMITTEE	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Jim Holbrook	Training Institution	<input checked="" type="checkbox"/> Reza Vaezazizi, MD	Medical Director
<input checked="" type="checkbox"/> Diana McCafferty	Private Ambulance Provider	<input checked="" type="checkbox"/> Virginia Hastings	Executive Director
<input checked="" type="checkbox"/> Marie Podboy	Air Ambulance Provider	<input checked="" type="checkbox"/> Denice Wicker-Stiles	Assistant Administrator
<input checked="" type="checkbox"/> Chad Clark, MD	ER/Trauma Physician	<input checked="" type="checkbox"/> Diane Fisher	Program Coordinator
<input type="checkbox"/> Kelly Bernatene, RN	EMS Nurse	<input checked="" type="checkbox"/> Julie Phillips	Supervising Office Assistant
<input type="checkbox"/> James Holmes	Hospital Administrator	<input checked="" type="checkbox"/> Mark Roberts	EMS Technical Consultant
<input type="checkbox"/> Stephen Miller	Law Enforcement	<input type="checkbox"/> Joe Lick	Staff Analyst II
<input checked="" type="checkbox"/> Michael Smith	Fire Chief	<input checked="" type="checkbox"/> Moises Evangelista	Statistical Analyst
<input checked="" type="checkbox"/> Troy Pennington, MD	Physician		
<input checked="" type="checkbox"/> Art Andres	EMT-P		
<input checked="" type="checkbox"/> Rick Britt	Communications		
<input type="checkbox"/> Vacant	Consumer Advocate		
<input type="checkbox"/> Vacant	City Manager Representative		
Art Rodriguez	Desert Ambulance	Ramon Lomeli	Morongo Basin Ambulance
Debbie Bervel	San Bernardino City Fire	Stacey Price	Loma Linda Fire
Susie Moss	American Medical Response	Ray Ramirez	Ontario Fire Department
Roy Cox	Mercy Air	Joe Powell	Rialto Fire
Patricia Apodaca	Barstow Fire	David Ouson	Victor Valley College
Joseph Guarrera	Apple Valley Fire	Bernie Horak	San Bernardino City Fire
Dale Gregory	San Bernardino County Sheriff Aviation	Joy Peters, RN	Arrowhead Regional Medical Center
Nancy Hernandez, RN	Loma Linda University Medical Center	Jeremy Ault	Chino Valley Fire
Pat McMahan	California Department of Corrections/Rehabilitation	Mike Donley	St. Bernardine's Medical Center
Michael May, RN	Loma Linda University Medical Center	Melanie Stanson	San Bernardino County Sheriff Aviation
Allen Francis	California Department of Corrections/Rehabilitation	Susan Scott	California Department of Corrections/Rehabilitation
Ron Baldwin	California Department of Corrections/Rehabilitation	Dennis King	California Department of Corrections/Rehabilitation
Christina Bivona-Tellez	Hospital Association of Southern California		

## I. CALL TO ORDER

The November 19, 2009 EMCC Meeting was called to order at 9:00 a.m.

\* Agenda Items VII. A. CIM Riot Overview (Jeremy Ault, Chino Valley Fire) and VII. B. H1N1/ILI Update (Maxwell Ohikhuare, M.D., Health Officer) were moved up and presented immediately following Call to Order.

## II. APPROVAL OF MINUTES

The September 17, 2009 EMCC Meeting Minutes were reviewed. Requested change; change Maria Podboy to Marie Podboy.

Vote on motion to approve minutes with above-requested change:

- ✚ Ayes: Eight (8)
- ✚ Noes: Zero
- ✚ Abstaining: Zero

Motion passed; minutes approved by consent.

## III. ICEMA UPDATE

Virginia Hastings discussed staffing changes within ICEMA- Iris Pena, RN, has accepted a position at Riverside Community Hospital. Hours for Jennifer Dearman, RN, have increased, and Jennifer will begin working with Dr. Vaezazizi on STEMI QI. Sherri Shimshy, RN, will continue with Medical Advisory Committee (MAC), Protocol and Education Committee, and general QI issues and problem solving. Additionally, approval for an EMS Specialist position will be presented to the Board of Supervisors hopefully in the next month.

### A. EMS MISS Status Report- Mark Roberts

ICEMA has received over 314,000 ePCR's to date. Approximately 16,500 new ePCR's are being added each month.

- 1) Defibrillator Interface- Providers trained on importing 12-lead data into ePCR:
  - a) AMR- Redlands
  - b) Baker EMS- Needles
  - c) Big Bear City Fire Bear Valley Paramedics Service
  - d) Big Bear Lake Fire Protection District
  - e) Morongo Basin Ambulance Association
  - f) Running Springs Fire Department
  - g) San Manuel Fire Department
  - h) Sierra Lifeflight- Inyo County
  - i) Symons Ambulance- Bishop Inyo County
- 2) College Instruction- ePCR utilized for paramedic instruction at:
  - a) Crafton Hills Community College
  - b) Victor Valley Community College
- 3) Daily Transmission of Data- Providers sending data to ICEMA server:

- a) AMR Rancho
- b) AMR Redlands
- c) AMR Victorville
- d) Baker EMS- Baker
- e) Baker EMS- Needles
- f) Barstow Fire Department
- g) Big Bear City Fire Bear Valley Paramedic Service
- h) Big Bear Lake Fire Protection District
- i) Desert Ambulance (third party import)
- j) Morongo Basin Ambulance Association
- k) Morongo Valley Fire Department
- l) Olancho/Cartago Fire Department (Inyo County)
- m) Running Springs Fire Department
- n) San Bernardino City Fire Department
- o) San Manuel Fire Department
- p) Sierra Lifeflight (Inyo County)
- q) Symons Ambulance- Bishop (Inyo County)
- r) Mercy Air (third party import)

4) Upcoming Dates- Implementation/training for additional providers:

- a) Sheriff's Aviation- 09/2009
- b) Apple Valley Fire Department- MOU Pending (Field Testing Go Live Date 01/01/2010)
- c) Big Pine Fire Department (Inyo County)- 12/2009
- d) CAL Fire City of Highland Fire Department- MOU Pending
- e) CAL Fire City of Yucaipa- MOU Pending
- f) Upland Fire Department- MOU Pending (training starts 12/2009/Go Live date 02/01/2010)
- g) Lone Pine Fire Department (Inyo County)- 12/2008
- h) Independence Fire Department (Inyo County)- MOU Pending

5) Third Party Interface to MISS

- a) Desert Ambulance (Zoll tabletePCR)- completed 04/2009; data received daily.
- b) Mercy Air (emsCharts)- completed and live data received daily
- c) ConFire (SUNPRO/ZOLL RMS)- continued use of paper 01A's in the field. Data entered into Sunpro RMS (Zoll data) after call; test data to ICEMA effective 02/01/2009. Problems identified during testing- data entry/mapping errors. ICEMA and ConFire met 08/24/2009 to work out said issues.

ICEMA Administration took a moment to ask all providers to be aware of the router boxes, and ensure that crews are not resetting or tampering with routers. Boxes were specifically made to house these routers, and a box from Loma Linda was tampered with and destroyed. Diana McCafferty asked Loma Linda for some follow up on this issue, so that a determination as to which crew is responsible; this matter will be pursued and this behavior will not be tolerated.

Virginia Hastings reported on the following:

### **B. Status- Trauma System Assessment**

The Trauma System Assessment Board Agenda Item has been filed; it was originally scheduled for the October 27, 2009 Agenda, but was postponed to December 15, 2009. In anticipation for the October Agenda, the report was distributed to all hospitals involved in the project, but has not been distributed more widely than that, as item has not gone to the Board. Virginia did report that there are no recommendations for new Trauma Hospitals at this time.

### **C. City of Upland- Request for Air Ambulance**

Upland Air Ambulance Permit and Air ALS Agreement were approved by the Board of Supervisors on Tuesday, November 17, 2009. ICEMA is anticipating an implementation date of February 1, 2010. A meeting will be scheduled with air providers to incorporate Upland Air into the FDZ priority listing. This contract does require that they use ePCR system. In addition, ICEMA is proceeding on the RFP; survey out now to hospitals, ICEMA has not yet received any responses.

## **IV. ICEMA MEDICAL DIRECTOR**

Reza Vaezazizi, M.D., reported on the following:

### **A. STEMI Update**

- 1) Interfacility Transfer of STEMI Patient Policy- Reference # 13205

Policy Reference # 13205 went into effect earlier this month; still too early to know impact on STEMI Program. This policy streamlines transfer process of STEMI patients, allows for dispatching of transporting units without traditional fire resource dispatch, and sets up an easy process for referring hospitals.

Questions/comments from EMCC Members:

- ✚ Dr. Pennington asked Dr. Vaezazizi if this policy is applicable to admitted patients. Dr. Vaezazizi reiterated that if a patient requires emergency access to the Cath Lab, by the way of a positive EKG clearly demonstrating a STEMI condition, the policy is applicable, whether inpatient or not.
- ✚ Dr. Vaezazizi will have this added to STEMI Committee Meeting Agenda.

Questions/comments from members of the public:

- ✚ Mike Donley from St. Bernardine's discussed St. Bernardine's concerns regarding Door to Balloon times and mechanical issue of getting patient from ER to Cath Lab.
- ✚ Dr. Vaezazizi reiterated that ICEMA is currently not including Interfacility Transfers in the 90-minute time clock that exists in EMS triage patients.

2) STEMI Base Hospital

ICEMA implemented a requirement for EMS paramedics to contact the Base Stations that are also STEMI Centers.

- ✚ San Bernardino County is one of a few counties with requirement of Cath Lab activation in EMS in the field.

**B. Zofran Trial Study**

EMS Commission unanimously approved Zofran as an Optional Scope medication, Category 1, in September. The counties in the study were given immediate approval to utilize their study protocols. Zofran has been placed on the December 16, 2009 MAC Agenda. Zofran Optional Scope will roll-out ICEMA-wide March 1, 2010. Study to be published in a peer review journal.

**C. Stroke Center Program**

Presently, ICEMA does not have a designated Stroke Center Program within its region. A few area hospitals have contacted ICEMA expressing interest in becoming a designated Stroke Center. ICEMA is in the early stages of looking at the development of an EMS Stroke Center Program. The process would mirror that of the STEMI System implementation: development of criteria, education, monitoring, MOUs, QI, etc. and will require 12-24 months to complete. More information to come at a later date.

**D. Paramedics as Vaccinators**

The State of California approved for a limited time utilizing paramedics as vaccinators, based upon a request from a local EMS Agency. Said approval is for regular seasonal flu vaccine and H1N1 vaccine, and term expires on January 1, 2010. Approval is limited to paramedics functioning as vaccinators of other EMS personnel with direct patient care responsibility.

**V. STANDING EMS SYSTEM MANAGEMENT REPORTS**

The following reports are available for review at <http://www.sbcounty.gov/icema/reports.htm>:

- ✚ Quarterly Trauma Hospital Report
- ✚ Base Hospital Quarterly Report
- ✚ Hospital Bed Delay Reports
- ✚ EMS System Management Reports

ICEMA staff is available to answer any questions and receive any comments regarding these reports.

**VI. OLD BUSINESS**

Reza Vaezazizi, M.D. reported on the following:

## A. Protocols

### 1) Reference # 6004 Adult Tachycardias

ICEMA Protocol Reference # 6004 Adult Tachycardias was originally going to be discussed at the previous EMCC Meeting; however, was held back pending additional feedback from the Medical Advisory Committee. Since that time, the Medical Advisory Committee has reviewed and made a few wording changes.

Questions/comments from EMCC Members:

- ✚ Chief Smith asked if Protocol # 6004 has gone through normal procedures/process and public comment period. ICEMA confirmed that it has.
- ✚ Maria Podboy motioned to approve Reference # 6004; Chad Clark, M.D. seconded.

Vote on motion to approve Reference # 6004 Adult Tachycardias:

- ✚ Ayes: Eight (8)
- ✚ Noes: Zero
- ✚ Abstaining: Zero

Protocol Reference # 6004 approved by consent.

### 2) Protocol Manual

Virginia Hastings advised the members of EMCC that ICEMA is preparing and will be distributing a new Protocol Manual, due to the numerous recent updates and changes. A change notice will be accompanying the manual, and electronic copies will be sent to each department.

## VII. NEW BUSINESS

### A. California Department of Corrections and Rehabilitation- California Institute for Men August 8, 2009 Prison Riot Overview- Captain Jeremy Ault, Chino Valley Fire Department

Captain Jeremy Ault presented an overview and power point of the California Institute for Men (CIM) Riot overview. Captain Ault discussed the logistics and described Unified Incident Command, triage, transportation, and hospitalization challenges relating to the unique patient population. The following are some highlights of said presentation.

- 1) Incident Responders included; Chino Valley Independent Fire District, CDCR, Corrections Fire, Chino Police Department, San Bernardino County Sheriff's Department, West End Task Force (requested for resources including Ontario, Montclair, Upland, and Rancho Cucamonga) CalFire, AMR, Cole-Schaeffer.
- 2) Inmates ruptured gas lines and set fires.
- 3) Prison physicians, nursing, and other prison facility personnel did a wonderful job of triaging hundreds of severely injured patients on the inside. The only patients sent

out of the prison ward to EMS were patients that required transport. Prison staff were extremely busy and sutured/treated hundreds of patients on the inside, running out of suture material. This made triage easier on EMS personnel. EMS only had 54 patients to treat.

- 4) EMS treated patients on different triage tarps which included Immediate, Delayed, and Minor. Unique to the patient population, two separate sets of tarps were required so that patients would not fight each other when they were brought outside. Armed guards were stationed around each set of tarps. Each transported patient had two (2) guards escorting, per CDCR policy.
- 5) Fire contained to building of origin.
- 6) No injuries to personnel inside or outside of the facility.
- 7) Zero fatalities.
- 8) Outstanding multi-agency cooperation!

Jim Holbrook applauded everyone involved in this process. He commended this clear example of inter-agency cooperation. Mr. Holbrook asked if Chief Ault has thought about writing this incident up. Chief Ault reiterated that the After Action Report is in process at this time, which mirrors ICEMA's MCI Policy.

Sociology of the riot was also discussed, and prison authorities were asked how the inmates on the inside behaved toward the severely injured: do they assist in identifying the most severely injured and/or protect their own? Prison authorities confirmed that inmates actually do bring their most severely injured to the door and then retreat, which was one of the ways it was possible to get the more severely injured inmates outside to EMS.

Virginia Hastings discussed the new ICEMA MCI Policy, and a copy of the Prison Hot Wash analysis was distributed to those who were directly involved in the handling of this incident.

## **B. H1N1/ILI Update- Maxwell Ohikhuare, M.D., Health Officer**

Dr. Ohikhuare presented updates on H1N1 Influenza Virus. The following are some important facts that were discussed with the EMCC:

- 1) The H1N1 outbreak started in mid-April in Mexico.
- 2) H1N1 is a "quadruple reassortant" virus; it has two genes from flu viruses that normally circulate in pigs in Europe and Asia, and one gene from birds, and one from humans.
- 3) The United States Government declared 2009 H1N1 a Public Emergency in April 2009; County of San Bernardino declared Emergency three days later.
- 4) June 11, 2009- World Health Organization raised Pandemic Alert to Phase 6.
- 5) October 23, 2009- President Obama declared 2009 National Emergency.
- 6) November 17, 2009- County of San Bernardino again declared Emergency.
- 7) California Data:
  - a) 2009 H1N1 predominant circulating influenza strain right now
  - b) Local Health Department reports hospitalized/fatality data weekly
  - c) Currently not reporting confirmed cases/no longer testing
  - d) Current State Data:
    - i) Hospitalizations= 5,380
    - ii) Pediatric patients= 1,914
    - iii) Pregnant women= 419

- iv) ICU patients=1,034
  - v) Deceased=297
    - ✚ Pregnant women fatality= 33
    - ✚ Pediatric fatality= 11
- e) Current San Bernardino County Data:
- i) Hospitalizations= 646
  - ii) Pregnant women= 65
  - iii) ICU patients= 39
  - iv) Non-ICU= 505
  - v) Deceased= 24 (16 males/8 females)
  - vi) Population ages 36-49 highest number of cases
  - vii) Population ages 50-64 second highest number of cases
  - viii) Population ages 25-35 third highest number of cases
  - ix) Zero cases in population ages >65
  - x) Zero cases in population age group 1-4
- f) H1N1 Vaccine comes in two (2) forms:
- i) Inactivated form- injection
  - ii) Nasal spray form- Live (attenuated) virus
- g) Private providers allowed to register/obtain direct shipment of vaccine.
- h) Current state allocation of H1N1 vaccine to San Bernardino County 235,000.
- i) Several Mass Flu Clinics throughout the county; approx. 14,000 residents vaccinated.
- j) Vaccine does **not** protect against seasonal flu.
- k) Outpatient testing no longer recommended (testing only hospitalized patients)
- l) October 12, 2009- Governor granted exemption from H&S 124172 (a) to use multi-dose for pregnancy.
- m) N95 continues to be the accepted Personal Protective Equipment (PPE) for H1N1.
- n) CDPH released 50% of State stockpile to counties, DPH and ICEMA will monitor requirements.
- o) FDA authorized use of Peramivir for hospitalized/critical patients- physicians must call CDC to request at (800) 782-4264.

### **C. EMCC Membership**

Virginia Hastings reported that there are now two (2) EMCC membership vacancies; Consumer Advocate Mark Cantrell resigned, and ER/Trauma Physician position will be vacant effective January 2010, as Chad Clark, M.D. has resigned.

### **D. HAVBED Reporting**

Diane Fisher presented a quick overview of requirements of HavBed Reporting. For the last month, ICEMA has been polling every hospital for HavBed availability, and gathering answers

to questions at the request of the Federal Government. Reporting occurs every Tuesday morning at 9:00 a.m., and ICEMA must receive responses by 2:00 p.m. in the afternoon.

#### **VIII. COMMITTEE/TASK FORCE REPORTS**

No questions or comments at this time.

#### **IX. OTHER/PUBLIC COMMENT**

- ✚ Jim Holbrook reported that on January 9, 2010 through January 10, 2010, San Bernardino County Fire Department and San Bernardino City Fire Department are to be recognized at the University of Tulane in New Orleans, LA as high performance organizations; congratulations!
- ✚ Christina Bovina-Tellez reported that Hospital Association of Southern California (HASC) is working on a 5150 study with collaborative efforts from other city, county, and state agencies.

#### **X. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING**

Jim Holbrook requested the following items be placed on the Agenda for January 2010.

- ✚ First Reading 2009 Annual Report
- ✚ 2010 EMCC Elections

#### **XI. NEXT MEETING DATE AND LOCATION**

**January 21, 2010**  
**City of Rancho Cucamonga-**  
**Council Chambers**  
**10500 Civic Center Drive**  
**Rancho Cucamonga, CA 91730**

#### **XII. ADJOURNMENT**

EMCC Meeting was adjourned at 10:51 a.m.

VH/RV/jcp

# Staff Report

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## ICEMA Reports Available on ICEMA WEB Page

ICEMA is going “green”.

The following ICEMA reports are available for review at  
<http://www.sbcounty.gov/icema/reports/reports.htm>

- Trauma System Report (Quarterly)
- Base Hospital Statistics (Quarterly)
- ePCR Submittals (Monthly)
- Bed Delay Report (Monthly)
- Medication, Procedures, and Type of Patient Summary Reports (Monthly)
- Reddinet Assessment Reports – ILI Hospital Assessment Poll (Updated frequently during flu season)

Staff will be available at the EMCC to answer any questions and receive comments regarding the reports.

# Staff Report

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## Utilization of PBC Trust Fund (Liquidated Damages)

*Current Balance:*

\$617,093 (through September 2009)

*Incidental Expenses:*

During the July 2008 meeting, the EMCC approved the use of liquidated damages for incidental expenses related to the MISS project or performance based contracts not to exceed \$5,000. Incidental expenses to date are as follows:

**APPROVED INCIDENTAL BUDGET** **\$5,000**

**EXPENSES:**

<b>Item</b>	<b>Vendor</b>	<b>Date</b>	<b>Amount</b>
Printer Cleaning Sheets	Office Depot	July 2008	\$22
Printer Servicing	Inland Computer	July 2008	\$55
Printer Cleaning Solution	Office Depot	August 2008	\$18
Toughbook Memory (18)	WareForce Corp.	August 2008	\$492
Printer wipes	Office Depot	September 2008	\$11
Printer Servicing	Inland Computer	September 2008	\$409
Toughbook Memory (13)	CDW-G	July 2009	\$483
Printer Servicing	Inland Computer	August 2009	\$474
Replace Desktop Harddrive	Office Depot	November 2009	\$155
Printer Servicing	Inland Computer	November 2009	\$219
Printer Servicing	Inland Computer	December 2009	\$360
<b>Total Spent</b>			<b>\$2,698</b>
Incidental Account Balance Remaining			\$2,302

*Additional Approved Expenses for FY2009-10:*

These expenditures were approved by the EMCC, but have not yet been withdrawn from the Trust Fund:

Printer Paper and Toner (September 2009 EMCC approval) \$ 28,000

# Staff Report

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## Utilization of PBC Trust Fund (Liquidated Damages) (continued)

### *Request for Additional Expenses for FY2009-10:*

In January 2007 ICEMA purchased 149 1GB Flash drives as part of the MISS project to use for transferring data from one provider to another provider (non-transporting fire to transporting provider). After months of use in the field it has become apparent the drives are breaking in as little as 8 weeks.

ICEMA is requesting authorization to purchase 150 rugged flash drives to replace the failing drives in the field. The rugged flash drives are made to be used by first responder, firefighters and law enforcement agencies. These new drives come with a 3 year warranty.

The total cost would be \$4,981.80



## MICN CERTIFICATION REQUIREMENTS

### PURPOSE

To define the requirements for Mobile Intensive Care Nurse (MICN) certification within the ICEMA Region.

### PROCEDURE

#### Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
  - a. Fee as set by ICEMA. The fee is not refundable or transferable.
  - b. Written verification of employment at a designated Base Hospital within the ICEMA Region.
  - c. Copy of front and back of a current, signed ACLS Card.
  - d. Copy of front and back of current California RN License.
3. 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.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.
5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.
  - a. A candidate who fails to pass the ~~ICEMA certification exam~~ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the ~~exam~~examination with a score of at least 85%.
  - b. A candidate who fails to pass the ~~ICEMA certification exam~~ICEMA written examination on the second attempt will have to pay the ICEMA approved

- fee, and provide documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures and pass the ~~ICEMA certification exam~~ICEMA written examination with a minimum score of 85%.
- c. If the candidate fails to pass the ~~ICEMA certification exam~~ICEMA written examination on the third attempt, the ~~ICEMA Medical Director will review the candidate's application to determine additional training requirements~~applicant must repeat the course and reapply.
6. A provisional MICN may function under the direct supervision of the Base Hospital MD, 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.
7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
9. 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.

### Continuous MICN Certification

1. Possess a current California RN License and current ICEMA MICN certification.
2. Submit the appropriate completed ICEMA application with:
  - a. Written verification of employment at a designated Base Hospital within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA)
  - b. Copy of front and back of a current, signed ACLS Card.

- c. Copy of front and back of current California RN License.
  - d. Documentation of eight (8) hours of field time.
  - e. Documentation of one (1) ICEMA approved Skills Day.
  - f. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
  - g. Documentation of two (2) ~~different~~ consecutive ICEMA Annual Review Class (ARC), ~~One~~ during each year of certification.
  - h. Continuous certification applicants not meeting this requirement must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a minimum score of 80%.
  - i. ~~Certification exam~~ ICEMA written examination does not replace or fulfill the requirement for a Skills Day or Field Care Audits. These must be completed prior to recertification.
3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
  4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.

### **MICN Recertification for RN's Working in a Non-Base Station Facility**

Applies to MICN's working in administrative/supervisory positions which have been approved by ICEMA:

- a. Must complete 2b through 2g above
- b. Must submit proof of employment with an approved non base station employer.
- c. Must teach or attend an additional skills day
- d. Must teach or attend an additional 6 hours of field care audits

If employment with approved entity is terminated the MICN must change status to inactive unless employed by a base hospital or another approved non base hospital employer.

### Inactive MICN Certification

1. Maintain a current California RN License.
2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.
  - a. Copy of front and back of a current, signed ACLS Card.
  - b. Copy of front and back of current California RN License.
  - c. Documentation of one (1) ICEMA approved Skills Day taken during the year of inactivation.
  - d. Documentation of ~~six~~four (64) hours of field care audits obtained within the ICEMA region.
  - e. Documentation of one (1) ICEMA Annual Review class for each year of inactivation.

### Return to Active MICN Status

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Hospital within the ICEMA Region.
- ~~2. Upon receipt of above documentation, and photo, the candidate will be scheduled for the ICEMA exam.~~
- ~~3. Upon passing the ICEMA certification exam with a minimum score of 80%, a provisional MICN card will be issued.~~
  - ~~a. A candidate who fails to pass the ICEMA certification exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of at least 85%.~~
  - ~~b. A candidate who fails to pass the ICEMA certification exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN or Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA exam with a score of at least 85%.~~

- ~~e. If the candidate fails to pass the ICEMA certification exam on the third attempt, the applicant will have to take and pass the ICEMA approved MICN course.~~
2. A provisional MICN may function under the direct supervision of the Base Hospital MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
  3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.
  4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
  5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates 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.

### **Certification by Challenge Examination**

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
  - a. MICN in another county within previous twelve (12) months
  - b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status
3. Submit the appropriate ICEMA application with:
  - a. Fee as set by ICEMA.
  - b. Written verification of employment at a designated Base Hospital within the ICEMA Region.
  - c. Copy of front and back of a current, signed ACLS Card.
  - d. Copy of front and back of current California RN License.

4. 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.
5. Upon completion of 1-4 above, the applicant will be scheduled to take the ~~ICEMA certification exam~~ICEMA written examination.
6. Upon passing the ~~ICEMA certification exam~~ICEMA written examination with a minimum score of 80%, a provisional MICN card will be issued.
  - a. A candidate who fails to pass the ~~ICEMA certification exam~~ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the ~~exam~~written examination with a minimum score of 85%.
  - b. ~~—A candidate who fails to pass the ICEMA certification exam~~ICEMA written examination -on the second attempt will be deemed ineligible for challenge certification. Applicant will need to take an ICEMA approved MICN course and comply with initial certification requirements. will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies/procedures given by their PLN and pass the exam with a minimum score of 85%.
  - c. ~~—If the candidate fails to pass the ICEMA certification exam on the third attempt, the ICEMA Medical Director will review the candidate's application to determine additional training requirements.~~
7. The individual may then function as a provisional MICN under the direct supervision of the Base Hospital MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.
8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
10. 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.



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## MICN CERTIFICATION REQUIREMENTS

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### PURPOSE

To define the requirements for Mobile Intensive Care Nurse (MICN) certification within the ICEMA Region.

### PROCEDURE

#### Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
  - a. Fee as set by ICEMA. The fee is not refundable or transferable.
  - b. Written verification of employment at a designated Base Station within the ICEMA Region.
  - c. Copy of front and back of a current, signed ACLS Card.
  - d. Copy of front and back of current California RN License.
3. 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.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.
5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.
  - a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a score of at least 85%.
  - b. A candidate who fails to pass the ICEMA written examination on the second attempt will have to pay the ICEMA approved fee, and provide

documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA written examination with a minimum score of 85%.

- c. If the candidate fails to pass the ICEMA written examination on the third attempt, the applicant must repeat the course and reapply.
6. A provisional MICN may function under the direct supervision of the Base Station MD, 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.
7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
9. 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.

### **Continuous MICN Certification**

1. Possess a current California RN License and current ICEMA MICN certification.
2. Submit the appropriate completed ICEMA application with:
  - a. Written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA)
  - b. Copy of front and back of a current, signed ACLS Card.
  - c. Copy of front and back of current California RN License.

- d. Documentation of eight (8) hours of field time.
  - e. Documentation of one (1) ICEMA approved Skills Day.
  - f. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
  - g. Documentation of two (2) consecutive ICEMA Annual Review Class (ARC), one during each year of certification.
  - h. Continuous certification applicants not meeting this requirement must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a minimum score of 80%.
  - i. ICEMA written examination does not replace or fulfill the requirement for a Skills Day or Field Care Audits. These must be completed prior to recertification.
3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
  4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.

### **MICN Recertification for RN's Working in a Non-Base Station**

Applies to MICN's working in administrative/supervisory positions which have been approved by ICEMA:

- a. Must complete 2b through 2g above
- b. Must submit proof of employment with an approved non base station employer.
- c. Must teach or attend an additional skills day
- d. Must teach or attend an additional 6 hours of field care audits

If employment with approved entity is terminated the MICN must change status to inactive unless employed by a base station or another approved non base station employer.

**Inactive MICN Certification**

1. Maintain a current California RN License.
2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.
  - a. Copy of front and back of a current, signed ACLS Card.
  - b. Copy of front and back of current California RN License.
  - c. Documentation of one (1) ICEMA approved Skills Day taken during the year of inactivation.
  - d. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
  - e. Documentation of one (1) ICEMA Annual Review class for each year of inactivation.

**Return to Active MICN Status**

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Station within the ICEMA Region.
2. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.
4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates 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.

**Certification by Challenge Examination**

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
  - a. MICN in another county within previous twelve (12) months
  - b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status
3. Submit the appropriate ICEMA application with:
  - a. Fee as set by ICEMA.
  - b. Written verification of employment at a designated Base Station within the ICEMA Region.
  - c. Copy of front and back of a current, signed ACLS Card.
  - d. Copy of front and back of current California RN License.
4. 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.
5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA written examination.
6. Upon passing the ICEMA written examination with a minimum score of 80%, a provisional MICN card will be issued.
  - a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the written examination with a minimum score of 85%.
  - b. A candidate who fails to pass the ICEMA written examination on the second attempt will be deemed ineligible for challenge certification. Applicant will need to take an ICEMA approved MICN course and comply with initial certification requirements.
7. The individual may then function as a provisional MICN under the direct supervision of the Base Station MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.

8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
10. 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.



## CARDIOVASCULAR “STEMI” RECEIVING CENTERS

### PURPOSE

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

### DEFINITIONS

1. **STEMI** - ST Elevation Myocardial Infarction.
2. **PCI** - Percutaneous Coronary Intervention.
3. **STEMI Receiving Center (SRC)** - Facilities that have emergency interventional cardiac catheterization capabilities.
4. **STEMI Referring Centers** - Facilities that do not have emergency interventional cardiac catheterization capabilities.
5. STEMI Base Station- Facilities that have emergency interventional cardiac catheterization capabilities that also function as a Base Station.
- ~~65.~~ **CQI** - Continuous Quality Improvement.
- ~~76.~~ **EMS** - Emergency Medical Services.
- ~~87.~~ **CE** -Continuous Medical Education.

### POLICY

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

1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.
2. Licensure as a Cardiac Catheterization Laboratory.
3. Intra-aortic balloon pump capability.

4. Cardiovascular surgical services permit:

*This requirement may be waived by the EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with existing American College of Cardiology/American Heart Association or other existing professional guidelines for standards.*

5. 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 CE opportunities for EMS personnel in areas of 12 Lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

7. **STAFFING REQUIREMENTS**

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

a. Medical Directors

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

b. Nursing Director

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

c. 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.

1. Cardiologist with percutaneous coronary intervention (PCI) privileges.
2. Cardiovascular Surgeon, if cardiovascular surgical services are offered.

*If cardiovascular surgical services 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 local EMS agency. Additionally, the facility must have a rapid transport agreement in place with a local transport agency.*

3. Cardiac Catheterization Laboratory team.
4. Intra-aortic balloon pump nurse or technologist.

## 8. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- a. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of an STEMI patient is not possible.
- b. Diversion of STEMI patients **only** during times of Internal Disaster in accordance to protocol # ~~140518070~~8060, Requests for Hospital Diversion, (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 facility.) A written notification describing the event must be submitted to ICEMA within twenty four (24) hours.
- c. Prompt acceptance of STEMI patients from other STEMI referral centers that do not have PCI capability.

e.d. ~~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.~~

## 9. DATA COLLECTION

The following data shall be collected on an on-going basis and available for review by ICEMA:

- a. Total number of EMS STEMI patients transported to a designated SRC. (Source data: ICEMA approved patient care record.)
- b. Total number of EMS STEMI patients that bypass the most accessible receiving hospital (not approved as a SRC) and are transported to a SRC. (Source data: base hospital logs.)

- c. Total number EMS STEMI patients who received primary PCI. (Source data: STEMI center logs.)
- d. Door to dilation times for primary PCI of all STEMI patients. (Source data: STEMI center logs.)
- e. Total number of patients admitted with the diagnosis of myocardial infarction per year. (Source data: STEMI center logs.)
- f. Total number of PCI procedures performed per year per facility. (Source data: STEMI center logs.)

#### 10. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

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

- a. Morbidity and mortality related to procedural complications.
- b. Detail review of cases requiring emergent rescue CABG.
- c. Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.
- d. Active participation in ICEMA STEMI CQI Committee activities.

#### 11. PERFORMANCE STANDARD

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

#### DESIGNATION

1. The Cardiovascular STEMI Receiving Center 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 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 criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

### **PATIENT DESTINATION**

1. The designated 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 and approved by a base hospital physician.
  - b. Total transport time to the 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. Base hospital contact is **mandatory** for all patients identified as possible STEMI patient. The base hospital confirms a SRC as the destination.
  - d. The base hospital is the only authority that can direct a patient to a STEMI receiving center.
  - e. The base 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.
2. The following factors should be considered with regards to choice of destination for STEMI patients. Base 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.



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### POLICY

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1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.
2. Licensure as a Cardiac Catheterization Laboratory.
3. Intra-aortic balloon pump capability.

## 4. Cardiovascular surgical services permit:

*This requirement may be waived by the EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with existing American College of Cardiology/American Heart Association or other existing professional guidelines for standards.*

## 5. 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 CE opportunities for EMS personnel in areas of 12 Lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

7. **STAFFING REQUIREMENTS**

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3. Cardiac Catheterization Laboratory team.
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The hospital shall develop internal policies for the following situations:

- a. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of an STEMI patient is not possible.
- b. Diversion of STEMI patients **only** during times of Internal Disaster in accordance to protocol #8060, Requests for Hospital Diversion, (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 facility.) A written notification describing the event must be submitted to ICEMA within twenty four (24) hours.
- c. Prompt acceptance of STEMI patients from other STEMI referral centers that do not have PCI capability.
- d. Cath lab team activation policy which requires immediate activation of the team upon EMS notification when there is documented STEMI patient enroute to the STEMI center, based on machine algorithm interpretation.

## 9. DATA COLLECTION

The following data shall be collected on an on-going basis and available for review by ICEMA:

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#### 10. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

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

- a. Morbidity and mortality related to procedural complications.
- b. Detail review of cases requiring emergent rescue CABG.
- c. Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.
- d. Active participation in ICEMA STEMI CQI Committee activities.

#### 11. PERFORMANCE STANDARD

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

#### DESIGNATION

- 1. The Cardiovascular STEMI Receiving Center 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 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 criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

### **PATIENT DESTINATION**

1. The designated 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 and approved by a base station physician.
  - b. Total transport time to the SRC is thirty (30) minutes or less. Base Station physician may override this requirement and authorize transport to the SRC with transport time of greater than thirty (30) minutes.
  - c. Base Station contact is **mandatory** for all patients identified as possible STEMI patient. The base station confirms a SRC as the destination.
  - d. The base station is the only authority that can direct a patient to a STEMI receiving center.
  - e. The base station, 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.
2. The following factors should be considered with regards to choice of destination for STEMI patients. Base station 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.



## BLS/ALS STANDARD DRUG & EQUIPMENT LIST

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

### MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS Transport	ALS Non-Transport	ALS Transport
Activated Charcoal 25 gm		2	2
Adenosine (Adenocard) 6 mg		1	1
Adenosine (Adenocard) 12 mg		2	2
Adrenaline (Epinephrine) 1:1000 1 mg		2	2
Adrenaline (Epinephrine) 1:10,000 1 mg preload		3	3
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg		4 doses	4 doses
Aspirin, chewable – 81mg tablet		1 bottle	1 bottle
Atropine 1 mg preload		4	4
Calcium Chloride 1 gm preload		1	1
Dextrose 25% 2.5 gm preload		2	2
Dextrose 50% 25 gm preload		2	2
Diphenhydramine (Benadryl) 50 mg		1	1
Dopamine 400 mg		1	1
Furosemide (Lasix) 40 mg		2	2
Glucagon 1 mg		1	1
Glucose paste	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg		4	4
Irrigating Saline and/or Sterile Water (1000cc)	2	1	2
Lidocaine 100 mg		3	3
Lidocaine 1gm or 1 bag pre-mixed 1gm/250cc D5W		1	1
Lidocaine 2% (Viscous) bottle		1	1
Magnesium Sulfate 10 gm		1	1
Naloxone (Narcan) 2 mg preload (needle less)		2	2
Nitroglycerine – Spray 0.4mg metered dose		1	2
Normal Saline for Injection (10cc)		2	2
Normal Saline 100cc		1	2
Normal Saline 250cc		1	1

Exchanged Medications/Solutions	BLS Transport	ALS Non-Transport	ALS Transport
Normal Saline 1000cc		3	6
<u>Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)</u>		<u>4</u>	<u>4</u>
<u>Ondansetron (Zofran) 4 mg IM/ IV</u>		<u>4</u>	<u>4</u>
Phenylephrine HCL - 0.5mg per metered dose		1 bottle	1 bottle
Procainamide 1 gm		1	2
Sodium Bicarbonate 50 mEq preload		2	2
Verapamil 5 mg		3	3

### CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange–MUST BE DOUBLE LOCKED	BLS Transport	ALS Non-Transport	ALS Transport
Midazolam – vials of 10mg/2cc, 2mg/2cc, or 5mg/5cc		20-40mg	20-40mg
Morphine Sulfate – ampules of 10mg or 15mg		20-60mg	30-60mg

### AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Adult non-rebreather mask	2	2	2
BAAM Device		1	2
End Title CO2 device – Pediatric and Adult (may be integrated into bag)		1	1
CPAP circuits- all manufacture's available sizes		2 each	2 each
Endotracheal Tubes cuffed – 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet		2 each	2 each
Endotracheal Tubes, uncuffed – 2.5, 3.0, 3.5		2 each	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5		2 each	2 each
ET Tube holders – pediatric and adult		1 each	2 each
Infant Simple Mask	1	2	2
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	SPECIALTY PROGRAMS ONLY 2 each	<u>1</u> 2 each	2 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	SPECIALTY PROGRAMS ONLY 2 each	<u>1</u> 2 each	2 each
Nasal cannulas – pediatric and adult	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr		1 each	1 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr		1 each	1 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each

<b>Exchanged Airway/Suction Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Needle Cricothyrotomy Device – Pediatric and adult or Needles for procedure 10ga, 12ga, 14ga, 15ga		1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent		1	1
Oropharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Pediatric non-rebreather O2 mask	2	2	2
Small volume nebulizer with universal cuff adaptor		2	2
Suction Canister 1200 cc	1	1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each	1 each	1 each
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent) Adult	1 each 1 each	1 each 1 each	1 each 1 each
Water soluble lubricating jelly		1	1
Yaunkers tonsil tip	1	1	1

<b>Non-Exchange Airway/Suction Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Ambulance Oxygen source –10L/min for 20 minutes	1		1
Flashlight/penlight	1	1	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight		1 each	1 each
Laryngoscope handle with batteries – or 2 disposable handles		1	1
Magill Forceps – Pediatric and Adult		1 each	1 each
Portable Oxygen with regulator – 10L/min for 20 minutes	1	1	1
Portable suction device (battery operated)	1	1	1
Pulse Oximetry device		1	1
Stethoscope	1	1	1
Wall mount suction device	1		1

**IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT**

<b>Exchanged IV/Needles/Syringes/Monitor Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Blood Tubing (Y type)			2
Conductive medium or Pacer/Defibrillation pads		2 each	2 each
Disposable Tourniquets		2	2
ECG electrodes – Pediatric and Adult		3 sets each	3 sets each
Glucose monitoring device with compatible strips and OSHA approved single use lancets		1	1

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS Transport	ALS Non-Transport	ALS Transport
EZ-IO Needles – Pts. 40kg or greater: 25mm, 15 gauge Pts. 3-39 kg: 15mm, 15 gauge LD needle <u>3-way stopcock with extension tubing</u>		2 each 1 each 1 <u>2</u>	2 each 1 each 1 <u>2</u>
IO Needles - sizes 16, 18, 20 gauge		1each	1 each
IV Catheters – sizes 14, 16, 18, 20, 22, 24		2 each	2 each
Microdrip Administration Set (60 drops/cc)		1	2
Macro drip Administration Set (10 drops/cc)		3	3
Pressure Infusion Bag (disposable)		1	1
Razors		2	2
Safety Needles – 20 or 21gauge and 23 or 25 gauge		2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2
Sterile IV dressing		2	2
Syringes w/wo safety needles – 1cc, 3cc, 10cc, 20cc, 60cc catheter tip		2 each	2 each

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

### OPTIONAL EQUIPMENT/MEDICATIONS

Optional Non-Exchange Equipment/Medications	BLS Transport	ALS Non-Transport	ALS Transport
AED/defib pads	2		
Ammonia Inhalants		2	2
Approved Automatic ventilator		1	1
Backboard padding	1	1	1
Bone Injection Drill (adult and pediatric)_or ICEMA approved IO device		2	2
Buretrol		1	1
Chemistry profile tubes		3	3

<b>Optional Non-Exchange Equipment/Medications</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
<del>Esophageal Tracheal Airway Device (ETAD) LA</del>		<u>2</u>	<u>2</u>
<del>Esophageal Tracheal Airway Device (ETAD) SA</del>		<u>2</u>	<u>2</u>
Gum Elastic intubation stylet		2	2
IV infusion pump		1	1
IV warming device		1	1
Manual IV Flow Rate Control Device			
Manual powered suction device	1	1	1
Multi-lumen peripheral catheter		2	2
Needle Thoracostomy Kit (prepackaged)		2	2
Pitocin		20 units	20 units
Translaryngeal Jet Ventilation Device		1	1
Vacutainer		1	1

### DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

<b>Exchanged Dressing Materials/Other Equip/Supplies</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Adhesive tape – 1 inch	2	2	2
Air occlusive dressing (Vaseline gauze)	1	1	1
Ankle & wrist restraints, soft ties acceptable	1	0	1
Antiseptic swabs/wipes		10	10
Bedpan or fracture pan	1		1
Urinal	1		1
Cervical Collars – Rigid Pediatric & Adult                    or	2 each	2 each	2 each
Cervical Collars – Adjustable Adult & Pediatric	2 each	2 each	2 each
Cold Packs	2	2	2
Emesis basin or disposable bags & covered waste container	1	1	1
Head immobilization device	2	2	2
OB Kit	1	1	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	4
Providence/Iodine swabs/wipes		10	10
Roller bandages – 4 inch	6	3	6
Sterile bandage compress or equivalent	6	2	6
Sterile gauze pads – 4x4 inch	4	4	4
Sterile Sheet for Burns	2	2	2
Universal Dressing 10x30 inches	2	2	2

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



## BLS/ALS STANDARD DRUG & EQUIPMENT LIST

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

### MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS Transport	ALS Non-Transport	ALS Transport
Activated Charcoal 25 gm		2	2
Adenosine (Adenocard) 6 mg		1	1
Adenosine (Adenocard) 12 mg		2	2
Adrenaline (Epinephrine) 1:1000 1 mg		2	2
Adrenaline (Epinephrine) 1:10,000 1 mg preload		3	3
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg		4 doses	4 doses
Aspirin, chewable – 81mg tablet		1 bottle	1 bottle
Atropine 1 mg preload		4	4
Calcium Chloride 1 gm preload		1	1
Dextrose 25% 2.5 gm preload		2	2
Dextrose 50% 25 gm preload		2	2
Diphenhydramine (Benadryl) 50 mg		1	1
Dopamine 400 mg		1	1
Furosemide (Lasix) 40 mg		2	2
Glucagon 1 mg		1	1
Glucose paste	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg		4	4
Irrigating Saline and/or Sterile Water (1000cc)	2	1	2
Lidocaine 100 mg		3	3
Lidocaine 1gm or 1 bag pre-mixed 1gm/250cc D5W		1	1
Lidocaine 2% (Viscous) bottle		1	1
Magnesium Sulfate 10 gm		1	1
Naloxone (Narcan) 2 mg preload (needle less)		2	2
Nitroglycerine – Spray 0.4mg metered dose		1	2
Normal Saline for Injection (10cc)		2	2
Normal Saline 100cc		1	2
Normal Saline 250cc		1	1

Exchanged Medications/Solutions	BLS Transport	ALS Non-Transport	ALS Transport
Normal Saline 1000cc		3	6
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)		4	4
Ondansetron (Zofran) 4 mg IM/ IV		4	4
Phenylephrine HCL - 0.5mg per metered dose		1 bottle	1 bottle
Procainamide 1 gm		1	2
Sodium Bicarbonate 50 mEq preload		2	2
Verapamil 5 mg		3	3

### CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange - MUST BE DOUBLE LOCKED	BLS Transport	ALS Non-Transport	ALS Transport
Midazolam – vials of 10mg/2cc, 2mg/2cc, or 5mg/5cc		20-40mg	20-40mg
Morphine Sulfate – ampules of 10mg or 15mg		20-60mg	30-60mg

### AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS Transport	ALS Non-Transport	ALS Transport
Adult non-rebreather mask	2	2	2
BAAM Device		1	2
End Title CO2 device – Pediatric and Adult (may be integrated into bag)		1	1
CPAP circuits- all manufacture's available sizes		2 each	2 each
Endotracheal Tubes cuffed – 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet		2 each	2 each
Endotracheal Tubes, uncuffed – 2.5, 3.0, 3.5		2 each	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5		2 each	2 each
ET Tube holders – pediatric and adult		1 each	2 each
Infant Simple Mask	1	2	2
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	SPECIALTY PROGRAMS ONLY 2 each	1 each	2 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	SPECIALTY PROGRAMS ONLY 2 each	1 each	2 each
Nasal cannulas – pediatric and adult	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr		1 each	1 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr		1 each	1 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each

<b>Exchanged Airway/Suction Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Needle Cricothyrotomy Device – Pediatric and adult or Needles for procedure 10ga, 12ga, 14ga, 15ga		1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent		1	1
Oropharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Pediatric non-rebreather O2 mask	2	2	2
Small volume nebulizer with universal cuff adaptor		2	2
Suction Canister 1200 cc	1	1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each	1 each	1 each
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent) Adult	1 each 1 each	1 each 1 each	1 each 1 each
Water soluble lubricating jelly		1	1
Yaunkers tonsil tip	1	1	1

<b>Non-Exchange Airway/Suction Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Ambulance Oxygen source –10L/min for 20 minutes	1		1
Flashlight/penlight	1	1	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight		1 each	1 each
Laryngoscope handle with batteries – or 2 disposable handles		1	1
Magill Forceps – Pediatric and Adult		1 each	1 each
Portable Oxygen with regulator – 10L/min for 20 minutes	1	1	1
Portable suction device (battery operated)	1	1	1
Pulse Oximetry device		1	1
Stethoscope	1	1	1
Wall mount suction device	1		1

**IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT**

<b>Exchanged IV/Needles/Syringes/Monitor Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
Blood Tubing (Y type)			2
Conductive medium or Pacer/Defibrillation pads		2 each	2 each
Disposable Tourniquets		2	2
ECG electrodes – Pediatric and Adult		3 sets each	3 sets each
Glucose monitoring device with compatible strips and OSHA approved single use lancets		1	1

<b>Exchanged IV/Needles/Syringes/Monitor Equipment</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
EZ-IO Needles – Pts. 40kg or greater: 25mm, 15 gauge Pts. 3-39 kg: 15mm, 15 gauge LD needle		2 each 1 each 1	2 each 1 each 1
3-way stopcock with extension tubing		2	2
IO Needles - sizes 16, 18, 20 gauge		1 each	1 each
IV Catheters – sizes 14, 16, 18, 20, 22, 24		2 each	2 each
Microdrip Administration Set (60 drops/cc)		1	2
Macro drip Administration Set (10 drops/cc)		3	3
Pressure Infusion Bag (disposable)		1	1
Razors		2	2
Safety Needles – 20 or 21gauge and 23 or 25 gauge		2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2
Sterile IV dressing		2	2
Syringes w/wo safety needles – 1cc, 3cc, 10cc, 20cc, 60cc catheter tip		2 each	2 each

<b>Non-Exchange IV/Needles/Syringes/Mon Equip</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
12 Lead ECG Monitor		1	1
Blood pressure cuff – large adult or thigh cuff, adult, child and infant	1	1	1
Defibrillator (adult and pediatric capabilities) with TCP and printout		1	1
Needle disposal system (OSHA Approved)		1	1
Thermometer Mercury Free with covers	1	1	1

**OPTIONAL EQUIPMENT/MEDICATIONS**

<b>Non-Exchange Optional Equipment/Medications</b>	<b>BLS Transport</b>	<b>ALS Non-Transport</b>	<b>ALS Transport</b>
AED/defib pads	2		
Ammonia Inhalants		2	2
Approved Automatic ventilator		1	1
Backboard padding	1	1	1
Bone Injection Drill (adult and pediatric)_or ICEMA approved IO device		2	2
Buretrol		1	1
Chemistry profile tubes		3	3
Gum Elastic intubation stylet		2	2



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



## EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

### MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	Amount
Adenosine (Adenocard) 6mg	30mg
Adrenaline (Epinephrine) 1:1,000	2mg
Adrenaline (Epinephrine) 1:10,000	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg	2 doses
Aspirin, chewable - 81mg tablet	1bottle
Atropine 1mg preload	3mg
Calcium Chloride	1gm
Dextrose 25%	50gm
Dextrose 50%	50gm
Diphenhydramine (Benadryl) 50mg	50mg
Furosemide (Lasix)	40mg
Glucagon	1mg
Intropin (Dopamine)	200mg
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Lidocaine	300mg
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250cc D5W	2gm
Lidocaine 2% (Viscous)	2oz
Magnesium Sulfate 10mg	10gms
Naloxone (Narcan)	10mg
Nitroglycerin – Spray/Tablets	1bottle
Normal Saline for Injection (10cc)	2
Normal Saline 250ml	1
Normal Saline 1000ml	4
<u>Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)</u>	<u>4</u>
<u>Ondansetron (Zofran) 4 mg IM/ IV</u>	<u>4</u>
Phenylephrine HCL - 0.5mg per metered dose	1bottle
Procainamide	1gm
Sodium Bicarbonate	100mEq

<b>Exchanged Medications/Solutions</b>	<b>Amount</b>
Verapamil (Isoptin)	15mg

**CONTROLLED SUBSTANCE MEDICATIONS**

<b>Non-Exchange Controlled Substance Meds – MUST BE DOUBLE LOCKED</b>	<b>Amount</b>
Midazolam – vials of 10mg / 2ml	20-40mg
Morphine Sulfate – ampules of 10mg	20-60mg

**AIRWAY/SUCTION EQUIPMENT**

<b>Single Use Airway/Suction Equipment</b>	<b>Amount</b>
BAAM Device	1
Endotracheal tubes, uncuffed – 2.5, 3.0, 3.5	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5	2 each
Endotracheal Tubes cuffed – 6.0, 7.0, 7.5 and 8.0	2 each
ET Tube holders – pediatric and adult	1 each
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	2 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	2 each
Malleable Stylet – pediatric and adult	1 each
Nasal Cannulas – infant, pediatric and adult	2 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Nasopharyngeal Airways – infant, child, and adult	1 each
Needle Cricothyrotomy Device (Approved) – Pediatric and adult <i>or</i>	1 each
Needles for procedure 10ga or 12ga, and 14ga, or 16ga	2 each
Non Re-Breather O <sub>2</sub> Mask – Pediatric and Adult	2 each
One way flutter valve with adapter or equivalent	1
Oropharyngeal Airways – infant, child, and adult	1 each
Small volume nebulizer with universal cuff adaptor	2
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags – Infant 250ml, Pediatric 500ml and Adult 1L	1 each
Water soluble lubricating jelly	1
Yaunkers tonsil tip	1



<b>Durable Items IV/Needles/Syringes/Monitoring Equipment</b>	<b>Amount</b>
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Thermometer	1

**OPTIONAL EQUIPMENT/MEDICATIONS**

<b>Optional Equipment/Medications</b>	<b>Amount</b>
Ammonia Inhalants	2
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
BLS/ALS Handheld Resuscitator (CAREvent <sup>®</sup> )	1
Bone Drill (adult & Peds) or ICEMA approved IO device	2
Chemistry profile tubes	3
D5W in bag	1
<del>Esophageal Tracheal Airway Device (ETAD) LA</del>	<del>2</del>
<del>Esophageal Tracheal Airway Device (ETAD) SA</del>	<del>2</del>
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Multi-lumen peripheral catheter	2
Needle Thoracostomy Kit (prepackaged)	2
Pitocin	20 units
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

**DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES**

<b>Single Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Adhesive tape – 1 inch	2
Air occlusive dressing (Vaseline gauze)	1
Ankle & wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Cervical Collars – Rigid Pediatric & Adult <i>or</i>	2 each
Cervical Collars – Adjustable Adult & Pediatric	2 each
Emesis basin or disposable bags & covered waste container	1
Head immobilization device	2
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4

<b>Single Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Providence/Iodine swabs/wipes	
Roller bandages – 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads – 4x4 inch	4
Sterile Sheet for Burns	2
Universal Dressing 10x30 inches	2

<b>Durable Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Aircraft stretcher or litter system with approved FAA straps	1
Bandage Shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards)	2
<del>Long board with restraint straps</del>	<del>1</del>
Pediatric immobilization board	1
Short extrication device	1
Traction splint	1



## EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

### MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	Amount
Adenosine (Adenocard) 6mg	30mg
Adrenaline (Epinephrine) 1:1,000	2mg
Adrenaline (Epinephrine) 1:10,000	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg	2 doses
Aspirin, chewable - 81mg tablet	1bottle
Atropine 1mg preload	3mg
Calcium Chloride	1gm
Dextrose 25%	50gm
Dextrose 50%	50gm
Diphenhydramine (Benadryl) 50mg	50mg
Furosemide (Lasix)	40mg
Glucagon	1mg
Intropin (Dopamine)	200mg
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Lidocaine	300mg
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250cc D5W	2gm
Lidocaine 2% (Viscous)	2oz
Magnesium Sulfate 10mg	10gms
Naloxone (Narcan)	10mg
Nitroglycerin – Spray/Tablets	1bottle
Normal Saline for Injection (10cc)	2
Normal Saline 250ml	1
Normal Saline 1000ml	4
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5mg per metered dose	1bottle
Procainamide	1gm
Sodium Bicarbonate	100mEq

<b>Exchanged Medications/Solutions</b>	<b>Amount</b>
Verapamil (Isoptin)	15mg

**CONTROLLED SUBSTANCE MEDICATIONS**

<b>Non-Exchange Controlled Substance Meds – MUST BE DOUBLE LOCKED</b>	<b>Amount</b>
Midazolam – vials of 10mg / 2ml	20-40mg
Morphine Sulfate – ampules of 10mg	20-60mg

**AIRWAY/SUCTION EQUIPMENT**

<b>Single Use Airway/Suction Equipment</b>	<b>Amount</b>
BAAM Device	1
Endotracheal tubes, uncuffed – 2.5, 3.0, 3.5	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5	2 each
Endotracheal Tubes cuffed – 6.0, 7.0, 7.5 and 8.0	2 each
ET Tube holders – pediatric and adult	1 each
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	2 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	2 each
Malleable Stylet – pediatric and adult	1 each
Nasal Cannulas – infant, pediatric and adult	2 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Nasopharyngeal Airways – infant, child, and adult	1 each
Needle Cricothyrotomy Device (Approved) – Pediatric and adult <i>or</i>	1 each
Needles for procedure 10ga or 12ga, and 14ga, or 16ga	2 each
Non Re-Breather O <sub>2</sub> Mask – Pediatric and Adult	2 each
One way flutter valve with adapter or equivalent	1
Oropharyngeal Airways – infant, child, and adult	1 each
Small volume nebulizer with universal cuff adaptor	2
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags – Infant 250ml, Pediatric 500ml and Adult 1L	1 each
Water soluble lubricating jelly	1
Yaunkers tonsil tip	1



<b>Durable Items IV/Needles/Syringes/Monitoring Equipment</b>	<b>Amount</b>
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Thermometer	1

### OPTIONAL EQUIPMENT/MEDICATIONS

<b>Optional Equipment/Medications</b>	<b>Amount</b>
Ammonia Inhalants	2
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
BLS/ALS Handheld Resuscitator (CAREvent <sup>®</sup> )	1
Bone Drill (adult & Peds) or ICEMA approved IO device	2
Chemistry profile tubes	3
D5W in bag	1
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Multi-lumen peripheral catheter	2
Needle Thoracostomy Kit (prepackaged)	2
Pitocin	20 units
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

### DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

<b>Single Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Adhesive tape – 1 inch	2
Air occlusive dressing (Vaseline gauze)	1
Ankle & wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Cervical Collars – Rigid Pediatric & Adult <i>or</i>	2 each
Cervical Collars – Adjustable Adult & Pediatric	2 each
Emesis basin or disposable bags & covered waste container	1
Head immobilization device	2
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4

<b>Single Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Providence/Iodine swabs/wipes	
Roller bandages – 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads – 4x4 inch	4
Sterile Sheet for Burns	2
Universal Dressing 10x30 inches	2

<b>Durable Use Dressing Materials/Other Equipment Supplies</b>	<b>Amount</b>
Aircraft stretcher or litter system with approved FAA straps	1
Bandage Shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards)	2
Pediatric immobilization board	1
Short extrication device	1
Traction splint	1

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NAUSEA AND VOMITING  
~~ZOFRAN (Ondansetron)~~  
~~PARAMEDIC TRIAL STUDY~~

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**FIELD ASSESSMENT/TREATMENT INDICATORS:**

1. Nausea
2. Vomiting

**CONTRAINDICATIONS:**

Known sensitivity to ondansetron or other 5-HT3 antagonists:

1. Granisetron (Kytril)
2. Dolasetron (Anzemet)
3. Palonosetron (Aloxi)

**PROCEDURE:**

1. Assess patient for need for anti-emetic therapy
2. Maintain airway
3. Position of comfort
4. Oxygen

**DOSAGE: PATENTS FOUR (4) YEARS OLD TO ADULT**

1. Ondansetron 4mg IM or slow IV push (greater than 30 seconds)
2. Ondansetron 4mg Oral Disintegrating Tablet (ODT)
3. For all children 4 years to 8 years old may give a total of 4mgs of ondansetron prior to Base Station contact.
4. For all children 9 and older: give ondansetron 4mgs and may repeat times two (2) for a total of 12 mgs prior to Base Station contact.
5. Base Hospital M may order a repeat dose of ondansetron 4 mg for continuing nausea or vomiting up to a total of 12 mgs.
6. May give Ondansetron 4mg with morphine to prevent vomiting.

**DOCUMENTATION:**

Documentation will be done on the electronic patient care record (ePCR). ~~Patient's response to the medication will be measured using the attached Visual Analog Scale for Nausea at fifteen (15) minute intervals after the administration and upon arrival at the receiving hospital.~~ The patient's response to the medication and vital signs will be documented on the ePCR.





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## NAUSEA AND VOMITING

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### FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Nausea
2. Vomiting

### CONTRAINDICATIONS:

Known sensitivity to ondansetron or other 5-HT<sub>3</sub> antagonists:

1. Granisetron (Kytril)
2. Dolasetron (Anzemet)
3. Palonosetron (Aloxi)

### PROCEDURE:

1. Assess patient for need for anti-emetic therapy.
2. Maintain airway.
3. Position of comfort.
4. Oxygen.

### DOSAGE: PATENTS FOUR (4) YEARS OLD TO ADULT

1. Ondansetron 4mg IM or slow IV push (greater than 30 seconds).
2. Ondansetron 4mg Oral Disintegrating Tablet (ODT).
3. For all children four (4) years to eight (8) years old may give a total of 4mgs of ondansetron prior to Base Station contact.
4. For all children nine (9) and older: give ondansetron 4mgs and may repeat times two (2) for a total of 12mgs prior to Base Station contact.
5. May repeat dose of ondansetron 4mg for continuing nausea or vomiting up to a total of 12mgs.
6. May give Ondansetron 4mg with morphine to prevent vomiting.

**DOCUMENTATION:**

Documentation will be done on the electronic patient care record (ePCR). The patient's response to the medication and vital signs will be documented on the ePCR.



## 12 LEAD ELECTROCARDIOGRAPHY

### ~~FIELD ASSESSMENT/TREATMENT INDICATORS~~

- ~~1. Patient suspected of having myocardial infarction (MI).~~
- ~~2. All chest pain patients or any patient at risk for a MI.~~
- ~~3. Consider atypical presentations:~~
  - ~~a) Elderly~~
  - ~~b) Female~~
  - ~~e) Diabetic~~
  - ~~d) Unexplained syncope~~
  - ~~e) Difficulty breathing~~
  - ~~f) General weakness in patients over fifty (50) years old~~
  - ~~g) Profound weakness~~
- ~~4. May be considered in patients with stable tachycardia for diagnostic purposes.~~

### ~~CONTRAINDICATIONS (RELATIVE)~~

- ~~1. Uncooperative patient.~~
- ~~2. Presence of unstable ventricular tachycardia, ventricular fibrillation, or 3rd degree AV block.~~
- ~~3. Life-threatening conditions.~~
- ~~4. Situations in which a delay to obtain ECG (greater than one (1) minute) would compromise care of the patient.~~

### ~~PROCEDURE~~

- ~~1. Complete initial assessment and stabilizing treatment (DO NOT DELAY TREATMENT FOR 12 LEAD).~~
- ~~2. May acquire 12 Lead at incident location or in vehicle just prior to beginning transport.~~
- ~~3. Place precordial lead electrodes and acquire tracing as per manufacturer's directions.~~
- ~~4. Relay ECG interpretation to base hospital. Assure that receiving hospital is advised if machine interpretation is "acute myocardial infarction suspected".~~
- ~~5. If defibrillation or synchronized cardioversion are necessary, place paddles or defibrillation electrodes, removing precordial leads, if necessary.~~

#### ~~DOCUMENTATION~~

- ~~1. Document the performance of 12 Lead ECG, the machine interpretation and the paramedic interpretation on prehospital care report (PCR).~~
- ~~2. Provide original tracing to receiving hospital. Attach copy of 12 Lead to Base Hospital copy, provider copy and ICEMA copy of PCR.~~

#### ~~SPECIAL CONSIDERATIONS~~

- ~~1. Approximate time to acquire 12 Lead should be no longer than three (3) minutes.~~
- ~~2. Do ECG prior to or when Nitroglycerin is administered as changes in ECG may occur with treatment.~~
- ~~3. Do not need to repeat 12 Lead performed at clinics or other similar settings unless patient's condition changes.~~
- ~~4. Machine interpretation of suspected STEMI may not be accurate in presence of paced rhythms, bundle branch blocks and certain tachydysrhythmias (e.g., SVT, atrial flutter). When communicating machine interpretation to base hospital, paramedics should advise base hospital of paced / BBB / tachydysrhythmia rhythms.~~



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## **12 LEAD ELECTROCARDIOGRAPHY**

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### **PURPOSE**

To identify guidelines for the acquisition, interpretation and transmission of a 12 lead ECG in the prehospital setting to facilitate early identification STEMI patients and prompt transportation to a STEMI Receiving Center (SRC).

### **POLICY**

Paramedics will obtain a 12 lead ECG in patients suspected of having acute coronary syndrome and provide treatment in accordance with this policy. Only paramedics who have received 12 lead ECG training are authorized to obtain a 12 lead ECG on patients.

### **INDICATIONS**

Any and all patients whose medical history and/or presenting complaints are consistent with an acute coronary syndrome. Patients will have one or more of the following:

1. Chest or upper abdominal discomfort suggestive of acute coronary syndrome.
2. New onset cardiac dysrhythmias (including adult cardiac arrest if return of spontaneous circulation).
3. Unexplained syncope or near syncope.
4. Unexplained acute generalized weakness with or without diaphoresis.
5. Acute onset of dyspnea suggestive of congestive heart failure.
6. Other signs or symptoms suggestive of acute coronary syndrome.
7. May be considered in patients with stable tachycardia for diagnostic purposes.
8. Any atypical presentation of symptoms that may be a suspected anginal equivalent.

### **CONTRAINDICATIONS (RELATIVE)**

1. Trauma.

2. Uncooperative patient.
3. Presence of unstable ventricular tachycardia, ventricular fibrillation, or 3rd degree AV block.

### **PROCEDURE**

1. Complete initial assessment and stabilizing treatment.
2. Recommend obtaining the ECG as soon as possible and prior to departing the scene.
3. Place precordial lead electrodes and acquire tracing as per manufacturer's directions.
4. Relay ECG interpretation to STEMI Receiving Base Station. Assure that the receiving hospital is advised if machine interpretation is "acute myocardial infarction" or "suspected acute myocardial infarction." (Exact machine interpretation is required for immediate cath-lab activation at the STEMI receiving hospital).
5. STEMI Base Station contact must be made in situations where the medic suspects a positive STEMI which is not supported by the ECG interpretation.
6. If defibrillation or synchronized cardioversion are necessary, place paddles or defibrillation electrodes, removing precordial leads if necessary.
7. The paramedic should transmit ECG to the receiving STEMI Center when available.

### **DOCUMENTATION**

1. Document the performance of 12 lead ECG, the machine interpretation and the paramedic interpretation on prehospital care report (PCR).
2. Provide original tracing to receiving hospital. Attach copy of 12 lead to hospital copy, provider copy and EMS copy of PCR.

### **DATA COLLECTION**

In order to continue STEMI quality improvement, the following data elements must be collected on each and every 12 lead ECG performed and provided to the receiving hospital with the patient:

1. A copy of the ePCR or O1A.
  - a. Patient identifiers.
  - b. Procedure performed (12 lead ECG).
  - c. Machine, paramedic and physician interpretations.
  - d. Additional ECG findings.
  - e. Rhythm.
2. A copy of the 12 lead ECG.
  - a. Patient identifiers.
  - b. Date 12 lead ECG performed.
  - c. Time 12 lead ECG performed.

#### **SPECIAL CONSIDERATIONS**

1. Approximate time to acquire 12 lead should be no longer than three (3) minutes.
2. Perform 12 lead ECG prior to or just as Nitroglycerin is administered as changes in the 12 lead ECG may occur with treatment.
3. 12 lead ECG does not need to be repeated, if originally performed at clinics or other similar settings unless patient's condition changes.
4. Machine interpretation of suspected STEMI may not be accurate in presence of paced rhythms, bundle branch blocks and certain tachydysrhythmias (e.g., SVT, atrial flutter). When communicating machine interpretation to base station, paramedics should advise station of paced / BBB / tachydysrhythmia rhythms.

# DRAFT

SAN BERNARDINO COUNTY  
EMERGENCY MEDICAL CARE COMMITTEE  
2009 ANNUAL REPORT

## INTRODUCTION

This writing is to document the San Bernardino County Emergency Medical Care Committee (EMCC) processes for 2009. Essentially the focus of the EMCC was to provide a platform for the diverse groups and individuals which form the Emergency Medical Services System, and also in the official capacity as an advisory group to the board of directors for Inland Counties Emergency Medical Agency.

The distinction between Emergency Medical Services (EMS) and Emergency Medical Care (EMC) needs to be reinforced. Emergency Medical Services are those processes that provide oversight and various components of infrastructure, where Emergency Medical Care is the effective and reliable treatment of ill or injured people. The bridge between these diverse constructs is multi-organizational where the relationship is both independent and interdependent. The system and individual complexity and requirements will continue to bring unique challenges to the region.

Our system continues to mature and is more formally exploring patient outcomes and other evidence based processes. San Bernardino County Emergency Services continues to advance the care and other services to ill or injured.

## EMCC MEMBERSHIP

The 2009 EMCC members were:

Emergency room or Trauma Physician - Chad Clark  
EMS nurse - Kelly Bernatene  
Fire Chief - Bill Smith  
Private ambulance provider - Diana McCafferty  
EMS training institution - Jim Holbrook  
Hospital administrator - James Holmes  
Law enforcement - Stephen Miller  
Emergency dispatch or communications center - Rick Britt  
Consumer Advocate - Mark Cantrell  
Physician - Troy Pennington  
City Manager - vacant  
Air ambulance provider - Marie Podboy  
Locally accredited paramedic - Art Andres

The EMCC position representing city manager went unfilled during the 2009 sessions. Bill Smith representing Fire Chiefs resigned and Mike Smith has been approved by the SB Co. Board of Supervisors to fill this position. Both Chad Clark representing Emergency Room Physicians and Mark Cantrell representing Consumer Advocate have formally resigned and no replacements have been approved.

All EMCC members are required to comply with the requirement for Ethics training as defined by Article 2.4 of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code (AB 1234).

## Manpower and Training

Both on-line and off-line medical control protocols continue to assure medical control of emergency medical care. A series of protocols, both regular updates and emergency protocols, were discussed during the 2009 EMCC sessions. The protocol changes were stimulated by changes in scientific or local system needs. A statewide implementation of the Physician Orders for Life-Sustaining Treatment (POLST) form and process was fully implemented as required by AB3000. Additionally a process for influenza-like illnesses

and other airborne infections was implemented.

Emergency medical care and quality patient outcomes and the measurements of those outcomes are continuing to advance within the system. The implementation of an accurate measure and documentation of outcomes of emergency medical care were more fully realized system wide and will remain a dynamic process. Following the full system wide implementation of data collection the review of system and quality assurance measures will need to be added to the processes already instituted.

The local training institutions, Victor Valley and Crafton Hills College, have implemented student training sessions on the use of electronic patient care documentation. The system continues through local provider and hospital based agency processes to forward the educational and training needs of the basic and advanced life support personnel system wide.

### **Communications**

The ability to communicate system issues including waiting to off load patients has shown progress as our larger system continues to meet these system challenges. Our entire system continues to explore and advance in the communication between all groups.

### **Transportation**

There were no new discussions on performance-based contracts or the restructuring of exclusive operating areas within the system during the 2009 sessions. There were committee deliberations on new permit requests for both air ambulance provider and special permits. Funding from the performance-based fines was added to other funding sources to augment the personnel and system needs of the region.

### **Assessment of Hospitals and Critical Care Centers**

As a standing committee report to the EMCC, hospital diversion data and provisional trauma reports were presented. Our system continues to face the same challenges as other emergency service systems trying to deal reliably with pre-hospital patient numbers and needs.

### **Medical Control**

Medical control continues to be provided through protocols and system review. During the 2009 EMCC sessions medical control systems advanced in four significant areas: 1) STEMI, 2) 12 Lead ECG competencies, 3) Zofran trail study, and 4) Annual review classes. These significant changes involved both the organizational and engineering controls necessary for reliable implementation.

### **Data Collection and Evaluation**

Our system continued to document progress in data collection and analysis during the 2009 sessions. Substantial agency(s) and personnel time were required in order to accurately collect, review, analyze, and compile reports for various discussions and decision making loops.

Continuing efforts have been made toward fully implementing electronic collection system wide. The system is moving out of the initial phase and some system outcome data exist. The transportation industry continues to be further along on the continuum of electronic transfer than public response agencies.

During the 2009 session the following San Bernardino County providers are sending data to the ICEMA server on a daily basis: 1) American Medical Response (AMR) Rancho, 2) AMR Redlands, 3) AMR Victorville, 4) Baker EMS - Baker, 5) Baker EMS - Needles, 6) Barstow Fire Department, 7) Big Bear City Fire Valley Paramedic Service, 8) Big Bear Lake Fire

Protection District, 9) Desert Ambulance, 10) Morongo Basin Ambulance Association, 11) Morongo Valley Fire Department, 12) Running Springs Fire Department, 13) San Bernardino City Fire Department, 14) San Manual Fire Department.

Memorandum of Understanding and full implementation is expected for the following agencies: 1) Apple Valley Fire Department, 2) CAL Fire City of Highland Fire Department, & 3) CAL Fire City of Yucaipa Fire Department, 4) Sheriff's Aviation, and 5) Upland Fire Department.

The following providers will be sending data to ICEMA as part of Confire: 1) Colton Fire Department, 2) Loma Linda Fire Department, 3) Redlands Fire Department, and 4) Rialto Fire Department. The following fire departments are pending the outcome of Confire testing: 1) Chino, 2) Crest Forest, 3) Montclair, 4) Ontario, and 5) Rancho Cucamonga.

#### **Public Information and Education**

As reported in past reports, due to changes in the administrative and structural process of the American Heart Association and other large network training agencies, an accurate number of individuals trained in cardiopulmonary resuscitation and first aid are not and will not be available.

#### **Disaster Response**

During this past year our local agencies responded to significant regional and state-wide large scale issues including the potential for significant threats. Chino Fire Department and the California Institution for Men presented on overview of the multiagency response to the prison riot.

#### **Conclusion**

It has been the goal of the EMCC to allow broad-based system participation and discussions. It is our sense that these activities have advanced our local system. The EMCC applauds our system and the participants as an amazing collection of the best and brightest in California.