



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Tom Lynch, EMS Administrator

Reza Vaezazizi, MD, Medical Director

DATE: June 30, 2015

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

FROM: Tom Lynch
EMS Administrator

Reza Vaezazizi, MD
Medical Director

SUBJECT: IMPLEMENTATION OF POLICIES/PROTOCOLS EFFECTIVE JULY 1, 2015

The policies/protocols listed below have been revised due to identified gaps between the protocols and Medication - Standard Orders, as well as clarification purposes, and are effective July 1, 2015.

- 6030 - AED Service Provider - Public Safety
- 6040 - AED Service Provider - Lay Rescuer
- 6060 - Specialty and Optional Scope Program Approval Policy
- 6090 - Fireline Paramedic
- 6110 - Tactical Medicine Program
- 7040 - Medication - Standard Orders
- 11010 - Respiratory Emergencies - Adult
- 11100 - Burns - Adult
- 14010 - Respiratory Emergencies - Pediatric

If you have any questions, please contact Ron Holk, RN, EMS Nurse at 909-388-5808 or via e-mail at Ron.Holk@cao.sbcounty.gov.

TL/RV/jlm

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POLICIES/PROTOCOLS CHANGES EFFECTIVE JULY 1, 2015

Reference #	Name	Changes
NEW		
None		
1000 ACCREDITATION AND CERTIFICATION		
None		
2000 DATA COLLECTION		
None		
3000 EDUCATION		
None		
4000 QUALITY IMPROVEMENT		
None		
5000 MISCELLANEOUS SYSTEM POLICIES		
None		
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
6030	AED Service Provider - Public Safety	Reformatted; added definitions; clarified application, approval and reporting process; forms location, due to regulatory changes.
6040	AED Service Provider - Lay Rescuer	Reformatted; clarified requirements and forms submission; forms location, due to regulatory changes.
6060	Specialty and Optional Scope Program Approval Policy	Reformatted; added definitions; clarified application and approval process; forms location.
6090	Fireline Paramedic	Referenced Deployment Notification form on ICEMA website; clarified application process/form.
6110	Tactical Medicine Program	
7000 STANDARD DRUG & EQUIPMENT LISTS		
7040	Medication - Standard Orders	Format, and references; clarified use of Albuterol and Atrovent MDI for specialty program.
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		
None		
9000 GENERAL PATIENT CARE POLICIES		
None		
10000 SKILLS		
None		
11000 ADULT EMERGENCIES		
11010	Respiratory Emergencies - Adult	Removed route - redundant.

POLICIES/PROTOCOLS CHANGES EFFECTIVE JULY 1, 2015

Reference #	Name	Changes
11100	Burns - Adult	Removed route - redundant.
12000 END OF LIFE CARE		
None		
13000 ENVIRONMENTAL EMERGENCIES		
None		
14000 PEDIATRIC EMERGENCIES		
14010	Respiratory Emergencies - Pediatric	Removed route - redundant
15000 TRAUMA		
None		
DELETIONS		
None		

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SERIES	SYSTEM POLICIES AND PROCEDURES	EFFECTIVE DATE
1000	ACCREDITATION, CERTIFICATION and AUTHORIZATION	
1020	EMR Certification	07/01/15
1030	EMT Certification	07/01/15
1040	EMT-P Accreditation	07/01/15
1050	MICN Authorization - Base Hospital, Administrative, Flight Nurse, Critical Care Transport	07/01/15
1060	Certification/Accreditation Review Policy	12/01/14
1070	EMT/AEMT Incident Investigation, Determination of Action, Notification, and Administrative Hearing Process	08/15/14
1090	Criminal History Background Checks (Live Scan)	08/15/14
1100	AEMT Certification	07/01/15
2000	DATA COLLECTION	
2010	Requirements for Patient Care Records	05/01/06
2020	ICEMA Abbreviation List	03/15/12
2030	Minimum Documentation Requirements for Transfer of Patient Care	03/15/12
2120	Instructions for the 01A/F1612 Forms	04/01/09
3000	EDUCATION	
3020	Continuing Education Provider Requirements	07/01/15
3030	EMT Continuing Education Requirements	03/15/11
4000	QUALITY IMPROVEMENT	
4010	Continuous Quality Improvement Plan	02/28/11
5000	MISCELLANEOUS SYSTEM POLICIES	
5010	Licensure Changes 911 Receiving Hospitals	01/01/10
5020	Base Hospital Selection Criteria	07/15/00
5030	Procedure for Adoption of Protocols and Policies	06/01/14
5040	Radio Communication Policy	03/15/11
5050	Medical Response to a Multi-Casualty Incident	04/01/13
5050 I/Mono Annex	Inyo and Mono Counties Medical Response to a Multi-Casualty Incident	05/01/11
5060	MCI Definitions/Key ICS Positions	01/01/10
5070	Medical Response to Hazardous Materials/Terrorism Incident	04/01/13
5080	ICEMA Ground Based Ambulance Rate Setting Policy-San Bernardino County	05/08/12
6000	SPECIALTY PROGRAM/ PROVIDER POLICIES	
6010	Paramedic Vaccination Policy	04/01/13
6030	AED Service Provider Policy - Public Safety	REVISED 07/01/15
6040	AED Service Provider - Lay Rescuer	REVISED 07/01/15
6060	Specialty and Optional Scope Program Approval Policy	REVISED 07/01/15
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and Destination Policy	12/01/14

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SERIES	SYSTEM POLICIES AND PROCEDURES	EFFECTIVE DATE
6000	SPECIALTY PROGRAM/ PROVIDER POLICIES (CONTINUED)	
6080	Paramedic Blood Draw for Chemical Test at the Request of a Peace Officer	04/01/13
6090	Fireline Paramedic REVISED	07/01/15
6100	Neurovascular Stroke Receiving Centers Criteria and Destination Policy <i>(San Bernardino County Only)</i>	12/01/14
6110	Tactical Medicine Program REVISED	07/01/15
6120	Emergency Medical Dispatch Center Requirements <i>(San Bernardino County Only)</i>	08/15/13
6130	Medical Priority Dispatch Minimum Response Assignments for Emergency Medical Dispatch (EMD) Categories	08/15/13
6140	Smoke Inhalation/CO Exposure/Suspected Cyanide Toxicity	06/01/14
6150	Trial Study Participation	03/01/15
7000	STANDARD DRUG & EQUIPMENT LISTS	
7010	BLS/LALS/ALS Standard Drug & Equipment List	06/01/15
7020	EMS Aircraft Standard Drug & Equipment List	06/01/15
7030	Controlled Substance Policy	06/01/15
7040	Medication - Standard Orders REVISED	07/01/15
8000	TRANSPORT/TRANSFERS AND DESTINATION POLICIES	
8010	Interfacility Transfer Guidelines	09/15/13
8020	Critical Care Interfacility Transport	12/01/14
8050	Transport of Patients (BLS)	02/01/92
8060	Requests for Hospital Diversion Policy <i>(San Bernardino County Only)</i>	04/01/13
8070	Aircraft Rotation Policy <i>(San Bernardino County Only)</i>	04/01/13
8090	Fort Irwin Continuation of Trauma Care	06/25/10
8110	EMS Aircraft Permit Policy	10/01/13
8120	Continuation of Care <i>(San Bernardino County Only)</i>	12/01/14
8130	Destination Policy	06/01/14
	PATIENT CARE POLICIES	
9000	GENERAL PATIENT CARE POLICIES	
9010	General Patient Care Guidelines	04/01/13
9020	Physician on Scene	04/01/13
9030	Responsibility for Patient Management Policy	04/01/13
9040	Reporting Incidents of Suspected Abuse Policy	04/01/13
9050	Organ Donor Information	04/01/13
9060	Local Medical Emergency Policy	02/01/14
9070	Applying Patient Restraints Guidelines	05/01/06
9080	Care of Minors in the Field	05/01/06
9090	Patient Refusal of Care - Adult	06/01/14
9110	Treatment of Patients with Airborne Infections & Transport Recommendations	09/15/11
9120	Nausea and Vomiting	12/01/14
10000	SKILLS	
10190	ICEMA Approved Skills	06/01/14

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11000	ADULT EMERGENCIES (15 YEARS OF AGE AND OLDER)	
11010	Respiratory Emergencies - Adult	REVISED 07/01/15
11020	Airway Obstruction - Adult	08/15/14
11040	Bradycardias - Adult	08/15/14
11050	Tachycardias - Adult	08/15/14
11060	Suspected Acute Myocardial Infarction (AMI)	06/01/15
11070	Cardiac Arrest - Adult	08/15/14
11080	Altered Level of Consciousness/Seizures - Adult	08/15/14
11090	Shock (Non-Traumatic)	08/15/14
11100	Burns - Adult	REVISED 07/01/15
11110	Stroke Treatment - Adult	12/01/14
12000	END OF LIFE CARE	
12010	Determination Of Death on Scene	08/15/14
	Coroners Worksheet of Death - EMS Report of Death Form	09/15/12
12020	Withholding Resuscitative Measures	10/01/14
13000	ENVIRONMENTAL EMERGENCIES	
13010	Poisonings	08/15/14
13020	Heat Related Emergencies	08/15/14
13030	Cold Related Emergencies	06/01/15
14000	PEDIATRIC EMERGENCIES (LESS THAN 15 YEARS OF AGE)	
14010	Respiratory Emergencies - Pediatric	REVISED 07/01/15
14020	Airway Obstruction - Pediatric	08/15/14
14030	Allergic Reactions - Pediatric	08/15/14
14040	Cardiac Arrest - Pediatric	08/15/14
14050	Altered Level of Consciousness - Pediatric	08/15/14
14060	Seizure - Pediatric	08/15/14
14070	Burns - Pediatric	06/01/15
14080	Obstetrical Emergencies	08/15/14
14090	Newborn Care	08/15/14
15000	TRAUMA	
15010	Trauma - Adult (15 years of age and older)	06/01/15
15020	Trauma - Pediatric (Less than 15 years of age)	06/01/15
15030	Trauma Triage Criteria & Destination Policy	08/15/14
15040	Glasgow Coma Scale Operational Definitions	04/01/13
15050	Hospital Emergency Response Team (HERT) Policy	10/15/13



AED SERVICE PROVIDER - PUBLIC SAFETY

I. PURPOSE

To establish a standard mechanism for approval of Public Safety automatic external defibrillator (AED) service providers in the ICEMA region.

II. DEFINITIONS

Firefighter: Any regularly employed and paid officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.

Lifeguard: Any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.

Peace Officer: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department.

Public Safety AED Service Provider: An agency or organization which is responsible for and is approved to operate an AED.

Public Safety Personnel: Any firefighter, peace officer, or lifeguard.

II. POLICY

Public Safety AED service providers shall be approved by ICEMA prior to beginning service. In accordance with California Code of Regulations, Title 22, Division 9, Chapter 1.5, approval may be revoked or suspended for failure to comply.

III. PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

Submit a Specialty and Optional Scope Program Approval Application, which is found on the ICEMA website at ICEMA.net (approval is required every two (2) years), with the following information to ICEMA for review and approval:

- Description of the geographic area served by the provider.

- The model name of the AED(s) to be utilized.
- Name of individual responsible for managing the AED program.
- Identify the primary instructor with qualifications.
- Identify the training program to be used.
- Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
- Procedures for maintenance of the AED.
- Policies and procedures to collect, maintain and evaluate patient care records.
- Identify the Medical Director responsible for the provider's AED program.

IV. RECORD KEEPING AND REPORTING REQUIREMENTS

- An AED Use Notification form, which is found on the ICEMA website at ICEMA.net, must be provided to the Public Safety AED service provider's Medical Director who is responsible for the provider's AED program within 24 hours of use.
- The following data shall be collected and reported to ICEMA annually by March 1st for the previous calendar year. An AED Annual Usage Report form is available on the ICEMA website at ICEMA.net.
 - The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known.
 - The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest.
 - The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
(909) 388-5823 FAX: (909) 388-5825

**AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
ANNUAL USAGE REPORT - PUBLIC SAFETY**

Name of AED Service Provider:	
Service Year:	
Number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known:	
Total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest:	
Number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation:	

Additional Comments Information:

FAX COMPLETED REPORT TO ICEMA WITHIN 24 HOURS OF USE OF AN AED

FAX TO 909-388-5825



AED SERVICE PROVIDER - LAY RESCUER

I. PURPOSE

To assist businesses and organizations implement Lay Rescuer automated external defibrillator (AED) service provider programs within the ICEMA region. Using (AEDs) for out-of-hospital cardiac arrests has been proven to increase survival rates. ICEMA supports the use of Lay Rescuer (non-licensed or non-certified personnel person) access AEDs within the ICEMA region, and this policy is intended to facilitate the proliferation of AED programs.

II. REQUIREMENTS OF BUSINESS/ORGANIZATION/INDIVIDUAL

- Become familiar and comply with California Code of Regulation, Title 22, Division 1.8.
- Complete an AED Site Notification form, which is found on the ICEMA website at ICEMA.net, listing each AED unit being deployed in the ICEMA region. Submit the form to:

ICEMA
1425 South "D" Street
San Bernardino, CA 92415-0060

- If any of the information becomes outdated, re-submit an AED Site Notification form (i.e., the AED is moved to a different location, a new AED is purchased, etc.), which is found on the ICEMA website at ICEMA.net.
- Every time an AED is used, complete the AED Use Notification form, which is found on the ICEMA website at ICEMA.net, and submit via fax to ICEMA at (909) 388-5825, within 24 hours of use.

III. IMPLEMENTATION CHECKLIST

Listed below are key elements taken from the California Code of Regulation, Title 22, Division 1.8. Each element must be satisfied to implement Lay Rescuer AED programs within the ICEMA region.

<input type="checkbox"/>	Notify ICEMA of the existence, location, and type of every AED within the ICEMA region. The business or organization responsible for the device must, at the time the device is acquired and placed, notify ICEMA. Complete an AED Site Notification form.
<input type="checkbox"/>	Expected AED users/rescuers must complete a training course in cardiopulmonary resuscitation (CPR) and in use of the AED device. The training curriculum must comply with regulations adopted by the California Emergency Medical Services Authority, the standards of the American Heart Association, or the American Red Cross. The training shall include a written and skills examination.
<input type="checkbox"/>	Any AED training course for non-licensed or non-certified personnel (Lay Rescuers) shall have a physician medical director.
<input type="checkbox"/>	A California licensed physician and/or surgeon must be involved in developing an internal emergency response plan for the site of the AED. The physician/surgeon is responsible for ensuring the businesses or organization's AED program complies with State regulations and requirements for training, notification, and maintenance. The internal emergency response plan shall include, but not be limited to, the provisions for immediate notification of 9-1-1 and AED-trained on-site personnel, upon discovery of the emergency. As well as procedures to be followed in the event of an emergency that may involve the use of an AED.
<input type="checkbox"/>	The business/organization/lay rescuer in possession of the AED must comply with all regulations governing the training, use, and placement of the device.
<input type="checkbox"/>	The AED must be maintained and regularly tested according to the manufacturer's operation and maintenance guidelines, the American Red Cross, and American Heart Association. Maintenance and testing must also comply with any applicable rules and regulations set forth by the US Food and Drug Administration and any other applicable authority.
<input type="checkbox"/>	The AED must be checked for readiness at least once every thirty (30) days and after each use. Records of these periodic checks shall be maintained by the business/organization in possession of the device.
<input type="checkbox"/>	A mechanism shall exist to ensure that any person rendering emergency care or using the AED activate the emergency medical services system (9-1-1) immediately. Further, the business/organization in possession of the AED is responsible for reporting any use of the AED to the physician medical director and to ICEMA. Complete an AED Use Notification form.
<input type="checkbox"/>	A mechanism shall exist that assures the continued competency of the expected AED users/ rescuers employed by the business/organization in possession of the AED. Such mechanism shall include periodic training and skills proficiency demonstrations sufficient to maintain competency.
<input type="checkbox"/>	For every AED unit acquired up to five (5) units, no less than one (1) employee per AED unit shall complete a training course in CPR and AED. After the first five (5) AED units are acquired, for each additional five (5) AED units acquired, one (1) additional employee shall be trained beginning with the first additional AED unit acquired. The business/organization in possession of the AED shall have trained employees available to respond to a cardiac emergency during normal operating hours.



SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL POLICY

I. PURPOSE

To provide guidelines for the application and renewal of advanced life support (ALS) or basic life support (BLS) specialty or optional scope of practice programs.

II. DEFINITIONS

AED Service Provider - Public Service: A specialty program for public safety personnel. (See ICEMA Reference #6040 - AED Service Provider - Public Safety.)

Emergency Medical Dispatch (EMD) Program: The reception, evaluation, processing and provision of dispatch life support; management of requests for emergency medical assistance; ongoing evaluation and improvement of the emergency medical dispatch process. (See ICEMA Reference #6120 - Emergency Medical Dispatch Center Requirements.)

Mobile Medic Specialty Program: A specialty program that utilizes boats, bicycles, motorcycles, golf carts and/or powered all-terrain vehicles or for ALS or BLS response designed to deliver EMT, AEMT, and/or EMT-P to the scene of injury and/or transport a patient from the scene of injury to other awaiting EMS units.

Optional Scope Program: Any EMT program that may require approval from the ICEMA Medical Director to function outside of the basic scope of practice that is not initiated region-wide.

Specialty Program: Any program that may require approval from the ICEMA Medical Director to function due to regulations or any variance from standard ICEMA policies or protocols either in equipment or procedures.

Tactical Medicine Program: A specialty program that meets all the prerequisites established by POST/EMSA for the delivery of emergency medical care during law enforcement special operations. (See ICEMA Reference #6110 - Tactical Medicine Program.)

III. POLICY

- All providers interested in providing ALS specialty or EMT optional scope programs shall submit an application which will undergo a review process to determine eligibility.
- All specialty and optional scope programs must submit a new application and be approved every two (2) years.

IV. PROCEDURE FOR SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL

- Submit an original application indicating the type of program. The Specialty and Optional Scope Program Approval Application is available on the ICEMA website at ICEMA.net.
- Submit a copy of the proposed or renewal program which shall include:
 - A statement demonstrating a need for the program.
 - A description of the geographic area within which the specialty program will be utilized.
 - A detailed description of the operation of the program (i.e. special events, 24/7) and how the program will be implemented.
 - A description of how the program will interface with the EMS system and 9-1-1.
 - A detailed description of the training program. For optional scope programs, include provisions for written test and demonstration of skills competencies.
 - A detailed list of employees participating in this program. If there are changes in employees ICEMA must be notified within 10 days.
 - A detailed description of any deviations from the Standard Drug and Equipment List, how equipment and drugs will be stored and/or transported and a program for maintenance of the equipment.
 - A process for the reporting of any deviations or adverse events.
 - A quality improvement plan or an amendment to the EMS providers Quality Improvement Plan that describes the quality improvement process for the specialty program. The plan must comply with all provisions of the ICEMA Quality Management Plan and include provisions for 100% review of all patient care reports in which the specialty or optional scope program was utilized.
- Additional procedures for Mobile Medic Specialty Programs:
 - A statement indicating compliance with Department of Motor Vehicles rules for personal safety equipment and/or vehicle registration.

- A list of type of vehicles utilized (bicycles, motorcycles, ATV).
- Type of patient care report (PCR) utilized and process for transfer of patient care documents in the field.
- Type of communication devices utilized and interface with ALS provider and transport.
- Additional procedures for EMT King Airway Optional Skills Program:
 - Accreditation for EMTs to practice optional skills is limited to those whose certificate is active and are employed within the ICEMA region by an authorized provider.
 - Training in the use of perilaryngeal airway adjuncts to include not less than five (5) hours with skills competency demonstration every 2 years for accredited EMTs in continuing programs.
 - Comply with state regulations for EMT Optional Skills training and demonstration of competency.

V. PROCEDURES FOR SPECIALTY PROGRAMS

- A patient care report is required for all patient contacts by EMS personnel (BLS or ALS) that result in a patient assessment. Patients refusing care or declining further care after treatment must sign a refusal of care and/or Against Medical Advise form.
- If paper forms are utilized, EMS Providers are required to submit an approved Electronic Patient Care Report (ePCR) by the end of shift or within 24 hours of the close of the event (whichever is less).
- Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.
- All patient care reports will be reviewed by the EMS Provider as part of their Continuous Quality Improvement program.

VI. DRUG AND EQUIPMENT LISTS

- Equipment and supplies carried and utilized by specialty program personnel shall be consistent and compatible with the drugs and equipment normally carried by ALS units.
- Equipment and supplies shall be based on the appropriate level of personnel utilized for the particular event.

VII. REFERENCES

Number	Name
6030	AED Service Provider - Public Safety
6110	Tactical Medicine Program
6120	Emergency Medical Dispatch Center Requirements



FIRELINE PARAMEDIC

I. PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic (EMT-P) deployed to function as a fireline paramedic (FEMP).

This protocol is for use by authorized FEMPs during fire suppression activities and treatment of fire suppression personnel only.

II. REQUIREMENTS

1. Must be a currently licensed paramedic in California.
2. Must be currently accredited paramedic in the ICEMA region.
3. Must be currently employed by an ICEMA approved ALS provider.
4. The FEMP will follow FIRESCOPE FEMP ICS 223-11 Position Manual and all other ICS protocols.
5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.
6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.
7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.
8. The FEMP may not perform skills outside of the ICEMA scope of practice.

III. PROCEDURE

1. The EMS provider will notify ICEMA of the deployment of the FEMP to an incident. Use the Fireline Paramedic (FEMP) Deployment Notification form, which is on the ICEMA website at ICEMA.net.
2. The FEMP will carry inventory in the advanced life support (ALS) pack as per the below inventory list (see Section IV. Fireline EMT-P (ALS) Pack

Inventory. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.

3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.
4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.
5. FEMP may carry an inventory of controlled substances (i.e., Fentanyl and Midazolam) if authorized by the employing agency’s Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.
6. Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.
7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care records will be reviewed by the provider agency and ICEMA for QI purposes.
8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with basic life support (BLS) treatment and supplies.

IV. FIRELINE EMT-P (ALS) PACK INVENTORY

Minimum Requirements: The weight of the pack will dictate if the EMT-P chooses to carry additional ALS supplies.

MEDICATIONS/SOLUTIONS

Medications/Solutions	ALS
Albuterol Solution 2.5 mg Handheld Nebulizer or Multidose Inhaler	4
Atropine Sulfate 1 mg	2
Ipratropium Bromide Solution 0.5 mg Handheld Nebulizer or Multidose Inhaler	4

Medications/Solutions	ALS
Lidocaine 100 mg IV pre-load	2
Aspirin 80 mg chewable	1 bottle
Dextrose 10%/250 ml (D10W 25 gm) IV/IO Bolus	1
Diphenhydramine 50 mg	4
Epinephrine 1: 10,000 1 mg	2
Epinephrine 1: 1000 1 mg	4
Glucagon 1 mg	1
Nitroglycerin spray 0.4 metered dose	1
Saline 0.9% IV 1000 ml may be divided in two 500 ml bags or four 250 ml bags.	

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	ALS
Midazolam	20 mg
Fentanyl (amount determined by the medical director)	200 - 400 mcg

ALS AIRWAY EQUIPMENT

Airway Equipment	ALS
Endotracheal Tubes - 6.0, 7.0 and/or 7.5 cuffed with stylet	1 each
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1 each
King Airway - Size 3, 4, and 5	1 each
ET Tube holder	1
End Tidal CO2 Detector	1
Needle Cricothyrotomy Kit	1
Needle Thoracostomy Kit	1

IV/MEDICATION ADMINISTRATION SUPPLIES

IV/Medication Administration Supplies	ALS
IV administration set macro drip	2
Venaguard	2
Alcohol preps	6
Betadine swabs	4
Tourniquet	2

IV/Medication Administration Supplies	ALS
Razor	1
Tape	1
IV catheters - 14, 16, 18 and 20 gauge	2
10cc syringe	2
1 cc TB syringe	2
18 gauge needle	4
25 gauge needle	2

MISCELLANEOUS EQUIPMENT

Miscellaneous	ALS
Sharps container	1
Narcotic storage per protocol	
FEMP pack inventory sheet	1
Patient care record or ePCR (Toughbook)	
AMA forms	3

Equipment	ALS
Compact AED or compact monitor defibrillator combination	
Appropriate cardiac pads	
Pulse oximetry (optional)	
Glucometer, test strips and lancets	4

The BLS pack and supplies will be carried by the FEMT or accompanying FEMP. Personal items and supplies cannot be carried in either the ALS pack or the BLS pack.



TACTICAL MEDICINE PROGRAM

I. PURPOSE

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

II. POLICY

1. Tactical Medicine Programs shall be developed and utilized in accordance with the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document that can be located on the EMSA website at ems.ca.gov.
2. Tactical Medicine Programs and their medical personnel (Emergency Medical Technicians (EMTs), Advanced EMT (AEMTs), Paramedics (EMT-Ps), and Registered Nurses (RNs)) shall be integrated into the local EMS system, in coordination with ICEMA, the local Emergency Medical Services (EMS) Agency (POST, 2010).
3. Tactical medicine programs shall be reviewed and approved by ICEMA.
4. Administration of this policy applies to EMTs, AEMTs, EMT-Ps, and RNs providing medical services within an established EMS Agency and as part of a recognized Tactical Medical Program.
 - a. The medical scope of practice for EMTs, AEMTs and EMT-Ps is consistent with Title 22, Division 9 and all ICEMA protocols.
5. Tactical Medicine Programs should designate a Tactical Medicine Program Director as defined within POST and EMSA guidelines.
6. Tactical Medicine Programs should designate a physician as a Tactical Medicine Medical Director “to provide medical direction, continuous quality improvement, medical oversight, and act as a resource for medical contingency planning” (POST, 2010).
7. Tactical Medicine Operational Programs should have components pertaining to planning, medical oversight, quality improvement and training as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.1-7).

8. Tactical Medicine Programs should include tactical medical personnel in mission planning and risk assessment to ensure appropriate assets are available for the identified mission as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.2).

III. PROCEDURE

1. All agencies that intend to provide a Tactical Medicine Program will:
 - a. Submit an original application indicating the type of program. The Specialty and Optional Scope Program Application is available on the ICEMA website at ICEMA.net.
 - b. Submit a copy of the proposed program to include all information as listed on the application.
 - c. Provide a list of all RNs, EMTs and EMT-Ps assigned to the Tactical Medicine Program.
 - d. Tactical medical personnel must be:
 - 1) EMT-Ps must be California licensed and accredited by ICEMA.
 - 2) EMTs and AEMTs must be California certified.
 - 3) RNs must be licensed as a Registered Nurse in California and an approved Flight Nurse, MICN, or EMT-P within the ICEMA region.
 - e. Participate in ICEMA approved Continuous Quality Improvement process.

IV. TRAINING

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

V. DRUG AND EQUIPMENT LISTS

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

appropriate level of personnel utilized for the particular Tactical Medicine Program (TEMS BLS or TEMS ALS).

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

TACTICAL MEDICINE OPERATIONAL EQUIPMENT RECOMMENDATIONS

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

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	BLS	ALS
Midazolam		20 mgs
Fentanyl		200 - 400 mcg

AIRWAY EQUIPMENT

Airway Equipment	BLS	ALS
Chest seal and Flutter Valve		1
End Tidal CO ₂ (device may be integrated into bag)		1
Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5 with stylet		1 each
ET Tube holder		1
King LTS-D Size 4 and 5	1 each if approved	1 each
Laryngoscope Kit		1
Nasopharyngeal Airways Adult	1 set	1 set
Needle Cricothyrotomy Device		1
Needle Thoracostomy Kit		1

Airway Equipment	BLS	ALS
Suction (hand held)	1	1
Ventilation Bag collapsible (BVM)	1	1

IV/MONITORING EQUIPMENT

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

DRESSING AND SPLINTING

Dressing/Splints	BLS	ALS
CoTCCC - Recommended tourniquet system	1	1
Elastic compression dressing	1	1
Latex free gloves	1	1
N95 Mask	1	1
Occlusive dressing	1	1
Roller bandage	1	1
Splint - semi-ridged moldable	1	1
Sterile gauze pads	1	1
Tape	1	1
Trauma dressing	1	1
Trauma shears	1	1
Triangle bandage	1	1
Hemostatic impregnated gauze non-exothermic, i.e., Combat Gauze (optional)	2	2

MISCELLANEOUS EQUIPMENT

Miscellaneous Equipment	BLS	ALS
Litter	1	1
Patient care record	1	1
Personal protection equipment (PPE)	1	1
Triage tags	10	10

Miscellaneous Equipment	BLS	ALS
Tactical light	1	1
Eyeware	1	1
Rescue blanket	1	1
Self-heating blanket	1	1



MEDICATION - STANDARD ORDERS

Adenosine (Adenocard) - Adult (ALS)

Stable narrow-complex SVT or Wide complex tachycardia:

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

Reference #s 7010, 7020, 11050

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

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

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

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

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

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Albuterol (Proventil) - Pediatric (LALS, ALS)

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

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

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

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

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Aspirin, chewable (LALS, ALS)

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

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

Atropine (ALS)

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

Organophosphate poisoning:

Atropine, 2 mg IV/IO, repeat at 2 mg increments every five (5) minutes if patient remains symptomatic.

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

Calcium Chloride (ALS)*Calcium Channel Blocker Poisonings:*

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

Reference #s 2020, 7010, 7020, 13010

Dextrose - Adult (LALS, ALS)

Dextrose 10%/250 ml (D10W 25 gm) IV/IO Bolus

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

Dextrose - Pediatric (LALS, ALS)

Hypoglycemia - Neonates (0 - 4 weeks) with blood glucose < 35 mg/dL or pediatric patients (greater than 4 weeks) with glucose < 60 mg/dL:

Dextrose 10%/250 ml (D10W 25 gm) 0.5 gm/kg (5 ml/kg) IV/IO

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

Diphenhydramine - Adult (ALS)

Diphenhydramine, 25 mg IV/IO

Diphenhydramine, 50 mg IM

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

Diphenhydramine - Pediatric (ALS)

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

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

Reference #s 7010, 7020, 14030

Dopamine - Adult (ALS)

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

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

Dopamine - Pediatric (ALS)

Post resuscitation continued signs of inadequate tissue perfusion:

9 to 14 years Dopamine, 400 mg in 250 ml of NS to infuse at 5 - 20 mcg/kg/min IV/IO titrated to maintain signs of adequate tissue perfusion.

Reference #s 7010, 7020, 14040

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

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

Epinephrine, 0.3 mg IM

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

For Persistent severe anaphylactic shock:

Epinephrine (1:10,000), 0.1 mg slow IVP/IO. May repeat every five (5) minutes as needed to total dosage of 0.5 mg.

Cardiac Arrest, Asystole, PEA:

Epinephrine, 1 mg IV/IO

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

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

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

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

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

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

Anaphylactic Shock (no palpable radial pulse and depressed level of consciousness):

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

Cardiac Arrest:

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

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

Newborn Care:

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

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

Post resuscitation continued signs of inadequate tissue perfusion:

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

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

Fentanyl - Adult (ALS)

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Isolated Extremity Trauma, Burns:

Fentanyl, 50 mcg slow IV/IO push over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg IV/IO, **or**

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Pacing, synchronized cardioversion:

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat in five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

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

Fentanyl - Pediatric (ALS)

Fentanyl, 0.5 mcg/kg slow IV/IO over one (1) minute. May repeat in five minutes titrated to pain, not to exceed 100 mcg.

Fentanyl, 1 mcg/kg IM/IN, may repeat every ten (10) minutes titrated to pain not to exceed 200 mcg.

Reference #s 2020, 6110, 7010, 7020, 7030, 11060, 13030, 14070, 15020

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

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

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

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

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

Reference #s 7010, 7020, 14050, 14060

Glucagon - Adult (LALS, ALS)

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

Betablocker Poisoning:

Glucagon, 1 mg IV/IO (base hospital order only)

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

Glucagon - Pediatric (LALS, ALS)

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

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

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

Atrovent, 0.5 mg nebulized. Administer one (1) dose only.

Reference #s 7010, 7020, 11010, 11100

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

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 11010, 11100

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

1 day to 12 months Atrovent, 0.25 mg nebulized. Administer one (1) dose only.

1 year to 14 years Atrovent, 0.5 mg nebulized. Administer one (1) dose only.

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

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

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Lidocaine - Adult (ALS)

Intubation, King Airway, NG/OG, for suspected increased intracranial pressure (ICP):

Lidocaine, 1.5 mg/kg IV/IO

VT/VF:

Initial Dose: Lidocaine, 1.5 mg/kg IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF.

VT/VF Infusion:

Lidocaine, 2 mg/min IV/IO drip

V-Tach, Wide Complex Tachycardia – with Pulses:

Lidocaine, 1.5 mg/kg slow IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF

Initiate infusion of Lidocaine 2 mg/min IV/IO drip.

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

Lidocaine - Pediatric (ALS)

Intubation, King Airway, NG/OG, for suspected increased intracranial pressure (ICP):

Lidocaine, 1.5 mg/kg IV/IO

Cardiac Arrest:

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

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

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

Reference #s 2020, 7010, 7020, 14040

Lidocaine 2% (Intravenous Solution) - Pediatric and Adult (ALS)

Pain associated with IO infusion:

Lidocaine , 0.5 mg/kg slow IO push over two (2) minutes, not to exceed 40 mg total.

Reference #s 2020, 7010, 7020, 10140

Magnesium Sulfate (ALS)

Polymorphic Ventricular Tachycardia:

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

Eclampsia (Seizure/Tonic/Clonic Activity):

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

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

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

Midazolam (Versed) - Adult (ALS)

Seizure:

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

Midazolam, 5 mg IM. May repeat in ten (10) minutes for continued seizure activity.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Pacing, synchronized cardioversion:

Midazolam, 2 mg slow IV/IO push or IN

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

Midazolam (Versed) - Pediatric (ALS)

Seizures:

Midazolam, 0.1 mg/kg IV/IO with maximum dose 2.5 mg. May repeat Midazolam in five (5) minutes, **or**

Midazolam, 0.2 mg/kg IM/IN with maximum dose of 5 mg. May repeat Midazolam in ten (10) minutes for continued seizure. IN dosage of Midazolam is doubled due to decreased surface area of nasal mucosa resulting in decreased absorption of medication.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 7010, 7020, 14060

Naloxone (Narcan) - Adult (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

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

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

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

Naloxone (Narcan) - Pediatric (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

1 day to 8 years	Naloxone, 0.1 mg/kg IV/IO
9 to 14 years	Naloxone, 0.5 mg IV/IO

May repeat every two (2) to three (3) minutes if needed. Do not exceed the adult dosage of 10 mg IV/IO/IM/IN.

Reference #s 7010, 7020, 14040, 14050

Nitroglycerin (LALS, ALS)

Nitroglycerin, 0.4 mg sublingual/transmucosal

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

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

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

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

Nausea/Vomiting:

Ondansetron, 4 mg slow IV/IO/ODT

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

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

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

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

Phenylephrine HCL (ALS)

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

Reference #s 7010, 7020, 10050

Procainamide (ALS)

SVT, V-Tach or Wide Complex Tachycardias:

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

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

Sodium Bicarbonate (ALS)

Tricyclic Poisoning:

Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #s 2020, 7010, 7020, 13010

Verapamil (ALS)

SVT if adenosine is ineffective:

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

Reference #s 7010, 7020, 11050



RESPIRATORY EMERGENCIES - ADULT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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

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

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Albuterol, with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.

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

V. REFERENCES

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

ACUTE PULMONARY EDEMA/CHF

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

- Be prepared to support ventilations as clinically indicated.

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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



BURNS - ADULT (15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. Manage Special Considerations

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

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

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

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

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

IV NS 500 ml/hour.
 - Transport to appropriate facility.
 - *Minor Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Moderate Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Major Burn Classification:* Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).
 - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate Trauma Center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

A. **Manage Special Considerations**

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

IV. **ALS INTERVENTIONS**

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

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

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

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

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

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

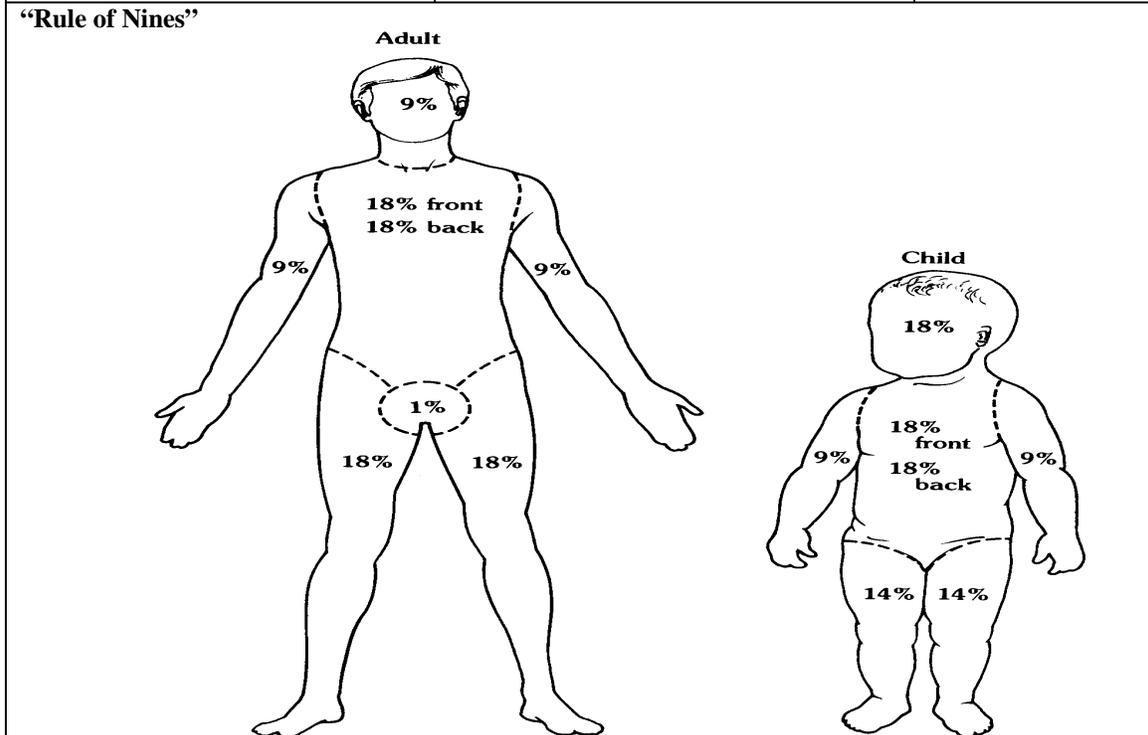
A. Manage Special Considerations

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

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

V. BURN CLASSIFICATIONS

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



VI. REFERENCES

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



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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Asthma
- Toxic Inhalation
- Difficult Breathing

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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



AED SERVICE PROVIDER ~~POLICY~~ - PUBLIC SAFETY

I. ~~PURPOSE~~

To establish a standard mechanism for ~~designation and~~ approval of Public Safety automatic external defibrillator (AED) service providers in the ICEMA region. ~~Public Safety Personnel is defined as Firefighter, ("Firefighter" means any regularly employed and paid officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district. Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.182, Health and Safety Code.) Peace Officer ("Peace officer" means any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department or other peace officer required by law to complete the training specified in this Chapter. Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.183, Health and Safety Code; and Section 13518, Penal Code.) and/or Lifeguard ("Lifeguard" means any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California. Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.182, Health and Safety Code.)~~

~~AUTHORITY~~

~~Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9, Chapter 1.5 First Aid Standards for Public Safety Personnel.~~

II. ~~DEFINITIONS~~

Firefighter: Any regularly employed and paid officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.

Lifeguard: Any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.

Peace Officer: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department.

Public Safety AED Service Provider: An agency or organization which is responsible for and is approved to operate an AED.

Public Safety Personnel: Any firefighter, peace officer, or lifeguard.

II. POLICY

Public Safety AED ~~Public Safety~~ service providers shall be approved by ICEMA prior to beginning service. In accordance with California Code of Regulations, Title 22, Division 9, Chapter 1.5, Approval may be revoked or suspended for failure to comply ~~with requirements of this policy or Title 22.~~

III. PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

~~Provider agencies that are seeking approval to implement AED services shall~~ submit an application for a specialty program a Specialty and Optional Scope Program Approval Application, which is found on the ICEMA website at ICEMA.net (approval is required every two (2) years), with the following information to ICEMA for review and approval:

- Description of the geographic area served by the provider ~~agency~~.
- The model name of the AED(s) to be utilized.
- ~~Identify the~~ Name of individual responsible for managing the AED program.
- Identify the primary instructor with qualifications.
- Identify the training program to be used.
- Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
- Procedures for maintenance of the AED.
- Policies and procedures to collect, maintain and evaluate patient care records.
- Identify the Medical Director responsible for the provider's AED program.

IV. RECORD KEEPING AND REPORTING REQUIREMENTS

- An AED Use Notification form, which is found on the ICEMA website at ICEMA.net, must be provided to the Public Safety AED service provider's Medical Director who is responsible for the provider's AED program within 24 hours of use.
- The following data ~~will~~shall be collected and reported to ICEMA annually by March 1st for the previous calendar year. An AED Annual Usage Report form is available on the ICEMA website at ICEMA.net.
 - The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known.
 - The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest.
 - The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
- ~~4. A listing of all public safety AED authorized personnel.~~



AED SERVICE PROVIDER - LAY RESCUER IMPLEMENTATION GUIDELINES

I. PURPOSE

~~This is a guidance document.~~ To assist businesses and organizations implement Lay Rescuer automated external defibrillator (AED) service provider programs within the ICEMA region. Using ~~automated external defibrillators~~ (AEDs) for out-of-hospital cardiac arrests has been proven to increase survival rates. ICEMA supports the use of Lay Rescuer (non-licensed or non-certified personnel person) access AEDs within the ICEMA region, and ~~this policy is these guidelines are~~ intended to facilitate the proliferation of AED programs.

AUTHORITY

- ~~1. California Health and Safety Code Sections 1797.5, 1797.107, 1797.190 and 1797.196.~~
- ~~2. California Code of Regulations Title 22, Division 9, Chapter 1.8 Sections 100031 through 100040, as revised January 8, 2009. (See Attachment C).~~

II. REQUIREMENTS OF BUSINESS/ORGANIZATION/INDIVIDUAL

- Become familiar and comply with California Code of Regulation, Title 22, Division 1.8 ~~AED regulations, and statutes, referenced above.~~
- Complete an AED Site Notification ~~of Defibrillator Site~~ form ~~(Attachment A)~~, which is found on the ICEMA website at ICEMA.net, listing each AED unit being deployed in the ICEMA region. Submit the form to:

ICEMA
1425 South "D" Street
San Bernardino, CA 92415-0060

- ~~Re-submit a Notification of Defibrillator Site form if~~ if any of the information becomes outdated, re-submit an AED Site Notification form (i.e., the AED is moved to a different location, a new AED is purchased, etc.), which is found on the ICEMA website at ICEMA.net.
- Every time an AED is used, complete the Report of Defibrillator AED Use Notification form, ~~(Attachment B)~~ which is found on the ICEMA website at ICEMA.net, and submit via fax to ICEMA at (909) 388-5825, within ~~twenty-four (24)~~ hours of use.

III. IMPLEMENTATION CHECKLIST

Listed below are key elements taken from the California Code of Regulation, Title 22, Division 1.8AED regulations and statutes. Each element must be satisfied to implement a Lay Rescuer AED programs within the ICEMA region.

<input type="checkbox"/>	Notify ICEMA of the existence, location, and type of every AED within the ICEMA region. The business or organization responsible for the device must, at the time the device is acquired and placed, notify ICEMA. (Attachment A) <u>Complete an AED Site Notification form.</u>
<input type="checkbox"/>	Expected AED users/rescuers must complete a training course in cardiopulmonary resuscitation (CPR) and in use of the AED device. The training curriculum must comply with regulations adopted by the California Emergency Medical Services Authority, the standards of the American Heart Association, or the American Red Cross. The training shall include a written and skills examination.
<input type="checkbox"/>	Any AED training course for non-licensed or non-certified personnel (Lay Rescuers) shall have a physician medical director.
<input type="checkbox"/>	A California licensed physician and/or surgeon must be involved in developing an internal emergency response plan for the site of the AED. The physician/surgeon is responsible for ensuring the businesses or organization's AED program complies with State regulations and requirements for training, notification, and maintenance. The internal emergency response plan shall include, but not be limited to, the provisions for immediate notification of 9-1-1 and AED-trained on-site personnel, upon discovery of the emergency. As well as procedures to be followed in the event of an emergency that may involve the use of an AED.
<input type="checkbox"/>	The business/organization/lay rescuer in possession of the AED must comply with all regulations governing the training, use, and placement of the device.
<input type="checkbox"/>	The AED must be maintained and regularly tested according to the manufacturer's operation and maintenance guidelines, the American Red Cross, and American Heart Association. Maintenance and testing must also comply with any applicable rules and regulations set forth by the US Food and Drug Administration and any other applicable authority.
<input type="checkbox"/>	The AED must be checked for readiness at least once every thirty (30) days and after each use. Records of these periodic checks shall be maintained by the business/organization in possession of the device.
<input type="checkbox"/>	A mechanism shall exist to ensure that any person rendering emergency care or using the AED activate the emergency medical services system (9-1-1) immediately. Further, the business/organization in possession of the AED is responsible for reporting any use of the AED to the physician medical director and to ICEMA. (Attachment B) <u>Complete an AED Use Notification form.</u>
<input type="checkbox"/>	A mechanism shall exist that assures the continued competency of the expected AED users/ rescuers employed by the business/organization in possession of the AED. Such mechanism shall include periodic training and skills proficiency demonstrations sufficient to maintain competency.
<input type="checkbox"/>	For every AED unit acquired up to five (5) units, no less than one (1) employee per AED unit shall complete a training course in CPR and AED. After the first five (5) AED units are acquired, for each additional five (5) AED units acquired, one (1) additional employee shall be trained beginning with the first additional AED unit acquired. The business/organization in possession of the AED shall have trained employees available to respond to a cardiac emergency during normal operating hours.

ATTACHMENT A

Notification of Defibrillator Site

Physician Medical Director Information	
Physician's Name:	
CA Medical License No:	
Physician's Phone No:	
I am serving as the Physician Medical Director for this defibrillation program as described in the California Code of Regulations, Section 100039. I hereby certify that the AED program described herein complies with all applicable laws and regulations, including placement, use, training, and maintenance of the device(s).	
Date:	_____ Signature:
On-Site Contact Information	
Name of On-Site Contact:	
Employer:	
Phone Number of On-Site Contact:	
Physical Address of On-Site Contact:	
Mailing Address of On-Site Contact:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

ATTACHMENT B

Notification of Defibrillator Site

Name Of AED Service Provider:	
Date of Occurrence:	
Time of Occurrence:	
Place of Occurrence: (Address & specific location)	
Patient's Name:	
Patient's Age:	
Patient's Sex:	
Approximate down time prior to your arrival:	
Did anyone witness the collapse/arrest?	
Alert Time (time you were notified):	
Was CPR used prior to AED at victim?	
Time of first shock (if given):	
Total number of shocks:	
Did victim regain a pulse at scene?	
Responder Name(s):	
Name and phone number of person completing form:	

Additional Comments Information:

FAX this completed report to ICEMA within twenty four (24) hours of use of an AED.
FAX to: (909) 388-5825



SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL POLICY

I. PURPOSE

To provide guidelines for ~~providers that currently have, or request to start an the~~ application and renewal of advanced life support (ALS) or basic life support (BLS) specialty or optional scope of practice programs.

AUTHORITY

~~Title 22, Division 9, Chapter 4, Sections 100144, 100145, 100147
CA Health and Safety Code Division 2.5 section 1797.214, 1797.220, 1797.196
EMT-I Regulations 100063.1~~

II. DEFINITIONS

AED Service Provider - Public Service: A specialty program for public safety personnel. (See ICEMA Reference #6040 - AED Service Provider - Public Safety.)

Emergency Medical Dispatch (EMD) Program: The reception, evaluation, processing and provision of dispatch life support; management of requests for emergency medical assistance; ongoing evaluation and improvement of the emergency medical dispatch process. (See ICEMA Reference #6120 - Emergency Medical Dispatch Center Requirements.)

Mobile Medic Specialty Program: A specialty program that utilizes boats, bicycles, motorcycles, golf carts and/or powered all-terrain vehicles or for ALS or BLS response designed to deliver EMT, AEMT, and/or EMT-P to the scene of injury and/or transport a patient from the scene of injury to other awaiting EMS units.

Optional Scope Program: Any EMT-I program that may require approval from the ICEMA Medical Director ~~or Executive Director~~ to function outside of the basic scope of practice that is not initiated region-wide.

Specialty Program: Any program that may require approval from the ICEMA Medical Director ~~or Executive Director~~ to function due to regulations or any variance from standard ICEMA policies or protocols either in equipment or procedures.

Tactical Medicine Program: A specialty program that meets all the prerequisites established by POST/EMSA for the delivery of emergency medical care during law enforcement special operations. (See ICEMA Reference #6110 - Tactical Medicine Program.)

III. POLICY

- All providers interested in providing ALS specialty or EMT-I optional scope programs shall submit an application which will undergo a review process to determine eligibility.
- All specialty and optional scope programs must ~~be re~~ submit a new application and be re approved every two (2) years.

IV. PROCEDURE FOR SPECIALTY AND OPTIONAL SCOPE PROGRAMS APPROVAL

- Submit an original application indicating the type of program. The Specialty and Optional Scope Program Approval Application is available on the ICEMA website at ICEMA.net.
- Submit a copy of the proposed or renewal program which shall include:
 - A statement demonstrating a need for the program.
 - A description of the geographic area within which the specialty program will be utilized.
 - A detailed description of the operation of the program (i.e. special events, 24/7) and how the program will be implemented.
 - A description of how the program will interface with the EMS system and 9-1-1.
 - A detailed description of the training program. For optional scope programs, include provisions for written test and demonstration of skills competencies.
 - A detailed list of employees participating in this program. If there are changes in employees ICEMA must be notified within 10 days.
 - ~~Any deviations from the Standard Drug and Equipment List. Submit a~~ A detailed description of any deviations from the Standard Drug and Equipment List, of the deviation, how equipment and drugs will be stored and/or transported and a program for maintenance of the equipment.
 - A process for the reporting of any deviations or adverse events.
 - A quality improvement plan or an amendment to the EMS providers Quality Improvement Plan that describes the quality improvement

process for the specialty program. The plan must comply with all provisions of the ICEMA Quality Management Plan and include provisions for 100% review of all patient care reports in which the specialty or optional scope program was utilized. Provide a quality improvement plan and process for reporting any deviations.

- Additional procedures for Mobile Medic Specialty Programs:
 - A statement indicating compliance with Department of Motor Vehicles rules for personal safety equipment and/or vehicle registration.
 - A list of type of vehicles utilized (bicycles, motorcycles, ATV).
 - Type of patient care report (PCR) utilized and process for transfer of patient care documents in the field.
 - Type of communication devices utilized and interface with ALS provider and transport.

- Additional procedures for EMT King Airway Optional Skills Program:
 - Accreditation for EMTs to practice optional skills is limited to those whose certificate is active and are employed within the ICEMA region by an authorized provider.
 - Training in the use of perilyngeal airway adjuncts to include not less than five (5) hours with skills competency demonstration every 2 years for accredited EMTs in continuing programs.
 - Comply with state regulations for EMT Optional Skills training and demonstration of competency.

V. PROCEDURES FOR SPECIALTY PROGRAMS

- A patient care report is required for all patient contacts by EMS personnel (BLS or ALS) that result in a patient assessment. Patients refusing care or declining further care after treatment must sign a refusal of care and/or Against Medical Advise form.

- If paper forms are utilized, EMS Providers are required to submit an approved Electronic Patient Care Report (ePCR) by the end of shift or within 24 hours of the close of the event (whichever is less).

- Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.

- All patient care reports will be reviewed by the EMS Provider as part of their Continuous Quality Improvement program.

VI. DRUG AND EQUIPMENT LISTS

- Equipment and supplies carried and utilized by specialty program personnel shall be consistent and compatible with the drugs and equipment normally carried by ALS units.
- Equipment and supplies shall be based on the appropriate level of personnel utilized for the particular event.

PROCEDURE FOR OPTIONAL SCOPE PROGRAMS

- ~~1. Submit an original application.~~
- ~~2. Submit a copy of the proposed program which shall include:
 - ~~a. A statement demonstrating a need for the program.~~
 - ~~b. A description of the geographic area within which the optional skill will be utilized.~~
 - ~~c. A detailed description of the operation of the program and how it will be implemented.~~
 - ~~d. A description of how the program will interface with the EMS system and 9-1-1.~~
 - ~~e. A detailed description of the training program including provisions for written test and demonstration of skills competency for optional scope.~~
 - ~~f. A detailed list of employees participating in program. If there are changes in employees, ICEMA must be notified within 10 days.~~
 - ~~g. Provide a quality improvement plan and processes for reporting any deviations.~~~~

VII. REFERENCES

<u>Number</u>	<u>Name</u>
<u>6030</u>	<u>AED Service Provider - Public Safety</u>
<u>6110</u>	<u>Tactical Medicine Program</u>
<u>6120</u>	<u>Emergency Medical Dispatch Center Requirements</u>



FIRELINE PARAMEDIC

I. PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic (EMT-P) deployed to function as a fireline paramedic (FEMP).

This protocol is for use by authorized FEMPs during fire suppression activities and treatment of fire suppression personnel only.

II. REQUIREMENTS

1. Must be a currently licensed paramedic in California.
2. Must be currently accredited paramedic in the ICEMA region.
3. Must be currently employed by an ICEMA approved ALS provider.
4. The FEMP will follow FIRESCOPE FEMP ICS 223-11 Position Manual and all other ICS protocols.
5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.
6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.
7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.
8. The FEMP may not perform skills outside of the ICEMA scope of practice.

III. PROCEDURE

1. The EMS provider will notify ICEMA of the deployment of the FEMP to an incident. Use the Fireline Paramedic (FEMP) Deployment Notification form, which is on the ICEMA website at ICEMA.net.
2. The FEMP will carry inventory in the advanced life support (ALS) pack as per the ~~attached below~~ inventory list (see Section IV. Fireline EMT-P (ALS))

Pack Inventory. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.

3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.
4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.
5. FEMP may carry an inventory of controlled substances (i.e., Fentanyl and Midazolam) if authorized by the employing agency’s Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.
6. Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.
7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care records will be reviewed by the provider agency and ICEMA for QI purposes.
8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with basic life support (BLS) treatment and supplies.

IV. FIRELINE EMT-P (ALS) PACK INVENTORY

Minimum Requirements. The weight of the pack will dictate if the EMT-P chooses to carry additional ALS supplies.

MEDICATIONS/SOLUTIONS

Medications/Solutions	ALS
Albuterol Solution 2.5 mg Handheld Nebulizer or Multidose Inhaler	4
Atropine Sulfate 1 mg	2
Ipratropium Bromide Solution 0.5 mg Handheld Nebulizer or Multidose Inhaler	4

Medications/Solutions	ALS
Lidocaine 100 mg IV pre-load	2
Aspirin 80 mg chewable	1 bottle
Dextrose 10%/250 ml (D10W 25 gm) IV/IO Bolus	1
Diphenhydramine 50 mg	4
Epinephrine 1: 10,000 1 mg	2
Epinephrine 1: 1000 1 mg	4
Glucagon 1 mg	1
Nitroglycerin spray 0.4 metered dose	1
Saline 0.9% IV 1000 ml may be divided in two 500 ml bags or four 250 ml bags.	

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	ALS
Midazolam	20 mg
Fentanyl (amount determined by the medical director)	200 - 400 mcg

ALS AIRWAY EQUIPMENT

Airway Equipment	ALS
Endotracheal Tubes - 6.0, 7.0 and/or 7.5 cuffed with stylet	1 each
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1 each
King Airway - Size 3, 4, and 5	1 each
ET Tube holder	1
End Tidal CO2 Detector	1
Needle Cricothyrotomy Kit	1
Needle Thoracostomy Kit	1

IV/MEDICATION ADMINISTRATION SUPPLIES

IV/Medication Administration Supplies	ALS
IV administration set macro drip	2
Venaguard	2
Alcohol preps	6
Betadine swabs	4
Tourniquet	2

IV/Medication Administration Supplies	ALS
Razor	1
Tape	1
IV catheters - 14, 16, 18 and 20 gauge	2
10cc syringe	2
1 cc TB syringe	2
18 gauge needle	4
25 gauge needle	2

MISCELLANEOUS EQUIPMENT

Miscellaneous	ALS
Sharps container	1
Narcotic storage per protocol	
FEMP pack inventory sheet	1
Patient care record or ePCR (Toughbook)	
AMA forms	3

Equipment	ALS
Compact AED or compact monitor defibrillator combination	
Appropriate cardiac pads	
Pulse oximetry (optional)	
Glucometer, test strips and lancets	4

The BLS pack and supplies will be carried by the FEMT or accompanying FEMP. Personal items and supplies cannot be carried in either the ALS pack or the BLS pack.



TACTICAL MEDICINE PROGRAM

I. PURPOSE

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

II. POLICY

1. Tactical Medicine Programs shall be developed and utilized in accordance with the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document that can be located on the EMSA website at: ~~http://www.emsa.ca.gov/personnel/files/Tactical~~ [Medicine.pdf](http://www.emsa.ca.gov/personnel/files/TacticalMedicine.pdf).
2. Tactical Medicine Programs and their medical personnel (Emergency Medical Technicians (EMTs), Advanced EMT (AEMTs), Paramedics (EMT-Ps), and Registered Nurses (RNs)) shall be integrated into the local EMS system, in coordination with ICEMA, the local Emergency Medical Services (EMS) Agency (POST, 2010).
3. Tactical medicine programs shall be reviewed and approved by ICEMA.
4. Administration of this policy applies to EMTs, AEMTs, EMT-Ps, and RNs providing medical services within an established EMS Agency and as part of a recognized Tactical Medical Program.
 - a. The medical scope of practice for EMTs, AEMTs and EMT-Ps is consistent with Title 22, Division 9 and all ICEMA protocols.
5. Tactical Medicine Programs should designate a Tactical Medicine Program Director as defined within POST and EMSA guidelines.
6. Tactical Medicine Programs should designate a physician as a Tactical Medicine Medical Director “to provide medical direction, continuous quality improvement, medical oversight, and act as a resource for medical contingency planning” (POST, 2010).
7. Tactical Medicine Operational Programs should have components pertaining to planning, medical oversight, quality improvement and training as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.1-7).

8. Tactical Medicine Programs should include tactical medical personnel in mission planning and risk assessment to ensure appropriate assets are available for the identified mission as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.2).

III. PROCEDURE

1. All agencies that intend to provide a Tactical Medicine Program will:
 - a. Submit an ~~original ICEMA approved~~ application indicating the type of program. ~~for a~~ The Specialty and Optional Scope Program Application is available on the ICEMA website at ICEMA.net. ~~for review by ICEMA.~~
 - b. Submit a copy of the proposed program to include all information as listed on the application.
 - c. Provide a list of all RNs, EMTs and EMT-Ps assigned to the Tactical Medicine Program.
 - d. Tactical medical personnel must be:
 - 1) EMT-Ps must be California licensed and accredited by ICEMA.
 - 2) EMTs and AEMTs must be California certified.
 - 3) RNs must be licensed as a Registered Nurse in California and an approved Flight Nurse, MICN, or EMT-P within the ICEMA region.
 - e. Participate in ICEMA approved Continuous Quality Improvement process.

IV. TRAINING

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

V. DRUG AND EQUIPMENT LISTS

Equipment and supplies carried and utilized by Tactical Emergency Medical Support (TEMS) personnel shall be consistent with the items listed in the California POST/EMSA *Tactical Medicine Operational Programs and Standardized Training*

Recommendations document. Equipment and supplies shall be based on the appropriate level of personnel utilized for the particular Tactical Medicine Program (TEMS BLS or TEMS ALS).

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

TACTICAL MEDICINE OPERATIONAL EQUIPMENT RECOMMENDATIONS

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

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	BLS	ALS
Midazolam		20 mgs
Fentanyl		200 - 400 mcg

AIRWAY EQUIPMENT

Airway Equipment	BLS	ALS
Chest seal and Flutter Valve		1
End Tidal CO ₂ (device may be integrated into bag)		1
Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5 with stylet		1 each
ET Tube holder		1
King LTS-D Size 4 and 5	1 each if approved	1 each
Laryngoscope Kit		1
Nasopharyngeal Airways Adult	1 set	1 set
Needle Cricothyrotomy Device		1
Needle Thoracostomy Kit		1

Airway Equipment	BLS	ALS
Suction (hand held)	1	1
Ventilation Bag collapsible (BVM)	1	1

IV/MONITORING EQUIPMENT

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

DRESSING AND SPLINTING

Dressing/Splints	BLS	ALS
CoTCCC - Recommended tourniquet system	1	1
Elastic compression dressing	1	1
Latex free gloves	1	1
N95 Mask	1	1
Occlusive dressing	1	1
Roller bandage	1	1
Splint - semi-ridged moldable	1	1
Sterile gauze pads	1	1
Tape	1	1
Trauma dressing	1	1
Trauma shears	1	1
Triangle bandage	1	1
Hemostatic impregnated gauze non-exothermic, i.e., Combat Gauze (optional)	2	2

MISCELLANEOUS EQUIPMENT

Miscellaneous Equipment	BLS	ALS
Litter	1	1
Patient care record	1	1
Personal protection equipment (PPE)	1	1
Triage tags	10	10

Miscellaneous Equipment	BLS	ALS
Tactical light	1	1
Eyewear	1	1
Rescue blanket	1	1
Self-heating blanket	1	1



MEDICATION - STANDARD ORDERS

Adenosine (Adenocard) - Adult (ALS)

Stable narrow-complex SVT or Wide complex tachycardia:

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

Reference #s 7010, 7020, 11050

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

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

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

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

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

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, and 14070 ~~Sheriff's Search and Rescue~~

Albuterol (Proventil) -- Pediatric (LALS, ALS)

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

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

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

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

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, and 14070

Aspirin, chewable (LALS, ALS)

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

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

Atropine (ALS)

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

Organophosphate poisoning:

Atropine, 2 mg IV/IO, repeat at 2 mg increments every five (5) minutes if patient remains symptomatic.

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

Calcium Chloride (ALS)

Calcium Channel Blocker Poisonings:

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

Reference #s 2020, 7010, 7020, 13010

Dextrose - Adult (LALS, ALS)

Dextrose 10%/250 ml (D10W 25 gm) IV/IO Bolus

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

Dextrose - Pediatric (LALS, ALS)

Hypoglycemia - Neonates (0 - 4 weeks) with blood glucose < 35 mg/dL or pediatric patients (greater than 4 weeks) with glucose < 60 mg/dL:

Dextrose 10%/250 ml (D10W 25 gm) 0.5 gm/kg (5 ml/kg) IV/IO

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

Diphenhydramine - Adult (ALS)

Diphenhydramine, 25 mg IV/IO

Diphenhydramine, 50 mg IM

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

Diphenhydramine - Pediatric (ALS)

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

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

Reference #s 7010, 7020, 14030

Dopamine - Adult (ALS)

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

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

Dopamine - Pediatric (ALS)

Post resuscitation continued signs of inadequate tissue perfusion:

9 to 14 years Dopamine, 400 mg in 250 ml of NS to infuse at 5 - 20 mcg/kg/min IV/IO titrated to maintain signs of adequate tissue perfusion.

Reference #s 7010, 7020, 14040

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

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

Epinephrine, 0.3 mg IM

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

For Persistent severe anaphylactic shock:

Epinephrine (1:10,000), 0.1 mg slow IVP/IO. May repeat every five (5) minutes as needed to total dosage of 0.5 mg.

Cardiac Arrest, Asystole, PEA:

Epinephrine, 1 mg IV/IO

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

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

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

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

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

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

Anaphylactic Shock (no palpable radial pulse and depressed level of consciousness):

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

Cardiac Arrest:

1 day to 8 years Epinephrine (1:10,000), 0.01 mg/kg IV/IO (do not exceed adult dosage)
9 to 14 years Epinephrine (1:10,000), 1.0 mg IV/IO

Newborn Care:

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

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

Post resuscitation continued signs of inadequate tissue perfusion:

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

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

Fentanyl - Adult (ALS)

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Isolated Extremity Trauma, Burns:

Fentanyl, 50 mcg slow IV/IO push over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg IV/IO, **or**

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Pacing, synchronized cardioversion:

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat in five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

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

Fentanyl - Pediatric (ALS)

Fentanyl, 0.5 mcg/kg slow IV/IO over one (1) minute. May repeat in five minutes titrated to pain, not to exceed 100 mcg.

Fentanyl, 1 mcg/kg IM/IN, may repeat every ten (10) minutes titrated to pain not to exceed 200 mcg.

Reference #s 2020, 6110, 7010, 7020, 7030, 11060, 13030, 14070, 15020

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

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

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

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

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

Reference #s 7010, 7020, 14050, 14060

Glucagon - Adult (LALS, ALS)

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

Betablocker Poisoning:

Glucagon, 1 mg IV/IO (base hospital order only)

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

Glucagon - Pediatric (LALS, ALS)

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

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

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

Atrovent, 0.5 mg nebulized. Administer one (1) dose only.

Reference #s 7010, 7020, 11010, 11100

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

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 11010, 11100

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

1 day to 12 months Atrovent~~nebulized~~, 0.25 mg nebulized. Administer one (1) dose only.

1 year to 14 years Atrovent~~nebulized~~, 0.5 mg nebulized. Administer one (1) dose only.

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

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

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Lidocaine - Adult (ALS)

Intubation, King Airway, NG/OG, for suspected increased intracranial pressure (ICP):

Lidocaine, 1.5 mg/kg IV/IO

VT/VF:

Initial Dose: Lidocaine, 1.5 mg/kg IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF.

VT/VF Infusion:

Lidocaine, 2 mg/min IV/IO drip

V-Tach, Wide Complex Tachycardia – with Pulses:

Lidocaine, 1.5 mg/kg slow IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF

Initiate infusion of Lidocaine 2 mg/min IV/IO drip.

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

Lidocaine - Pediatric (ALS)

Intubation, King Airway, NG/OG, for suspected increased intracranial pressure (ICP):
Lidocaine, 1.5 mg/kg IV/IO

Cardiac Arrest:

1 day to 8 years Lidocaine, 1.0 mg/kg IV/IO
9 to 14 years Lidocaine, 1.0 mg/kg IV/IO

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

Reference #s 2020, 7010, 7020, 14040

Lidocaine 2% (Intravenous Solution) - Pediatric and Adult (ALS)*Pain associated with IO infusion:*

Lidocaine , 0.5 mg/kg slow IO push over two (2) minutes, not to exceed 40 mg total.

Reference #s 2020, 7010, 7020, 10140

Magnesium Sulfate (ALS)*Polymorphic Ventricular Tachycardia:*

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

Eclampsia (Seizure/Tonic/Clonic Activity):

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

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

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

Midazolam (Versed) - Adult (ALS)*Seizure:*

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

Midazolam, 5 mg IM. May repeat in ten (10) minutes for continued seizure activity.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of ~~IV/IO~~/IM/IN/~~IV/IO~~ may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Pacing, synchronized cardioversion:

Midazolam, 2 mg slow IV/IO push or IN

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

Midazolam (Versed) - Pediatric (ALS)

Seizures:

Midazolam, 0.1 mg/kg IV/IO with maximum dose 2.5 mg. May repeat Midazolam in five (5) minutes, **or**

Midazolam, 0.2 mg/kg IM/IN with maximum dose of 5 mg. May repeat Midazolam in ten (10) minutes for continued seizure. IN dosage of Midazolam is doubled due to decreased surface area of nasal mucosa resulting in decreased absorption of medication.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of ~~IM/IN~~/IV/IO-~~IM/IN~~ may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 7010, 7020, 14060

Naloxone (Narcan) - Adult (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

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

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

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

Naloxone (Narcan) - Pediatric (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

1 day to 8 years	Naloxone, 0.1 mg/kg IV/IO
9 to 14 years	Naloxone, 0.5 mg IV/IO

May repeat every two (2) to three (3) minutes if needed. Do not exceed the adult dosage of 10 mg IV/IO/IM/IN.

Reference #s 7010, 7020, 14040, 14050

Nitroglycerin (LALS, ALS)

Nitroglycerin, 0.4 mg sublingual/transmucosal

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

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

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

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

Nausea/Vomiting:

Ondansetron, 4 mg slow IV/IO/ODT

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

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

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

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

Phenylephrine HCL (ALS)

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

Reference #s 7010, 7020, 10050

Procainamide (ALS)

SVT, V-Tach or Wide Complex Tachycardias:

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

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

Sodium Bicarbonate (ALS)

Tricyclic Poisoning:

Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #s 2020, 7010, 7020, 13010

Verapamil (ALS)

SVT if adenosine is ineffective:

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

Reference #s 7010, 7020, 11050



~~ADULT~~ RESPIRATORY EMERGENCIES - ADULT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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

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

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

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

V. REFERENCES

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

ACUTE PULMONARY EDEMA/CHF

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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



BURNS - ADULT (15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. Manage Special Considerations

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

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

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

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

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

IV NS 500 ml/hour.
 - Transport to appropriate facility.
 - *Minor Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Moderate Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Major Burn Classification:* Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).
 - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate Trauma Center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

A. **Manage Special Considerations**

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

IV. **ALS INTERVENTIONS**

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

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

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

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

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

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

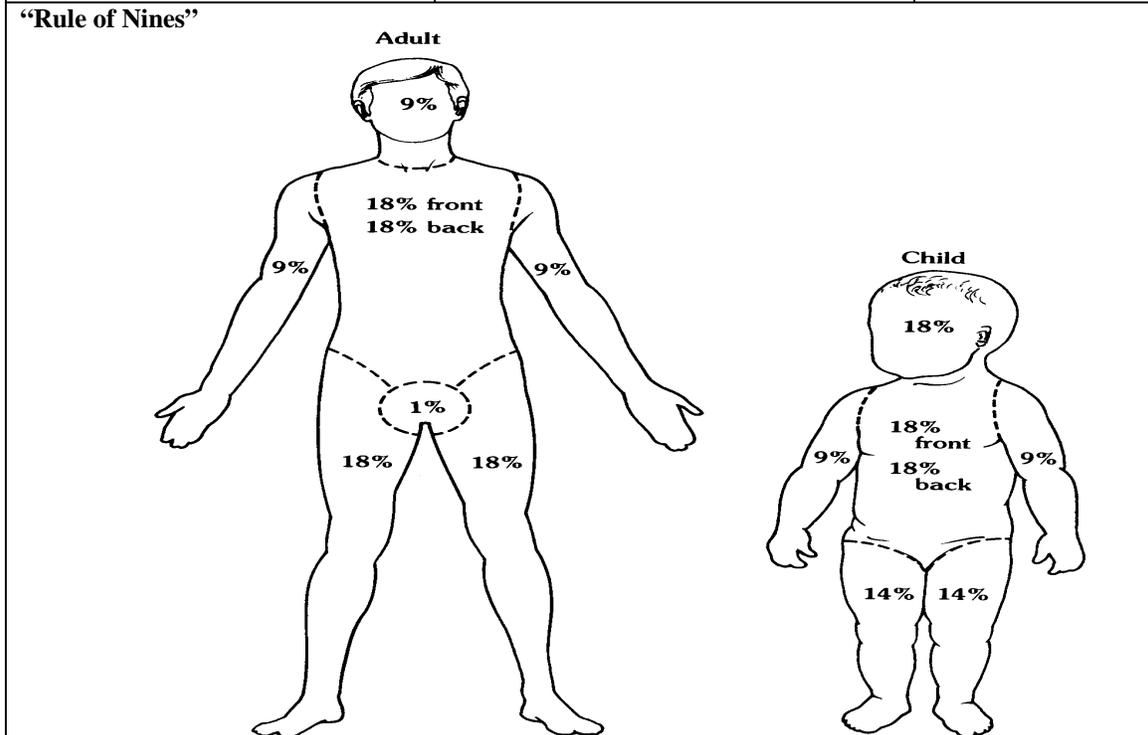
A. Manage Special Considerations

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

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

V. BURN CLASSIFICATIONS

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



VI. REFERENCES

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



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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Asthma
- Toxic Inhalation
- Difficult Breathing

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

V. REFERENCES

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