



## AGENDA

### ICEMA MEDICAL ADVISORY COMMITTEE

August 25, 2016

1300

Purpose: Information Sharing

Meeting Facilitator: Phong Nguyen

Timekeeper: Chantae Wilson

Record Keeper: Chantae Wilson

	AGENDA ITEM	PERSON(S)	DISCUSSION/ACTION
I.	Welcome/Introductions	Phong Nguyen	
II.	Approval of Minutes	All	Discussion/Action
III.	Discussion/Action Items		
	A. Standing EMS System Updates		
	1. Trauma Program 2. STEMI Program <ul style="list-style-type: none"> <li>• Society of Cardiovascular Patient Care</li> </ul> 3. Stroke Program 4. CQI Report Update <ul style="list-style-type: none"> <li>• Core Measures</li> </ul> 5. SAC Update	1. Chris Yoshida-McMath 2. Chris Yoshida-McMath  3. Chris Yoshida-McMath 4. Ron Holk  5. Phong Nguyen	2. Discussion 3. Discussion  4. Discussion 5. Discussion  6. Discussion
	B. EMS Trends		
	1. TXA Study Update 2. Paramedicine Step I Research Update 3. Cardiac Arrest Survival Enhancement Project (CARES/ART)	1. Reza Vaezazizi/ Michael Neeki 2. Michael Neeki 3. Reza Vaezazizi	1. Discussion  2. Discussion 3. Discussion
	C. Needle Cricothyrotomy	All	Discussion/Action
	D. Axial Spinal Immobilization	Chris Yoshida-McMath	Discussion/Action
	E. EMD Alpha Determinates	Reza Vaezazizi	Discussion
	F. Local Optional Scope of Practice: <ul style="list-style-type: none"> <li>• Pediatric Intubation</li> <li>• Nasotracheal Intubation</li> <li>• Oxytocin</li> <li>• Procainamide</li> <li>• Verapamil</li> <li>• Hydroxocobalamin (Cyanokit)</li> <li>• King Airway - EMT</li> </ul>	Reza Vaezazizi	Discussion/Action

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	G. ePCR User Interface Task Force	Leslie Parham	Discussion
	H. Protocol Updates	Ron Holk	Discussion/Action
	1. 7040 - Medication-Standard Orders		
	2. 8090 - Fort Irwin Continuation of Trauma		
	3. 9010 - General Patient Care Guidelines		
	4. 12010 - Determination of Death On Scene		
	5. 12020 - Withholding Resuscitative Measures		
IV.	Public Comment	All	Discussion
V.	Round Table/Announcements	All	Discussion
VI.	Future Agenda Items	All	Discussion
VII.	Next Meeting Date: October 27, 2016	All	Discussion
VIII.	Adjournment	Phong Nguyen	Action
IX.	Closed Session		
	A. Case Reviews		



## MINUTES

### ICEMA MEDICAL ADVISORY COMMITTEE

June 23, 2016

1300

	AGENDA ITEM	DISCUSSION/FOLLOW UP	RESPONSIBLE PERSON(S)
I.	WELCOME/INTRODUCTIONS	Meeting called to order at 1307.	Phong Nguyen
II.	APPROVAL OF MINUTES	The April 28, 2016, minutes were approved.  Motion to approve. MSC: Stephen Patterson/Sam Chua Ayes: Phong Nguyen, Sam Chua, Debbie Bervel, Joy Peters, Joe Powell, Leslie Parham, Susie Moss, Lance Brown, Stephen Patterson, Kevin Parkes	
III.	DISCUSSION ITEMS		
	A. Standing EMS System Updates		
	1. Trauma Program	The next TSAC/TAC meeting is scheduled on July 13, 2016.	Chris Yoshida-McMath
	2. STEMI Program: STEMI Data	The next STEMI meeting is scheduled on August 4, 2016.	Chris Yoshida-McMath
	<ul style="list-style-type: none"> <li>Chest Pain Society Accreditation</li> </ul>	ICEMA had an informational meeting on May 10, 2016, with the Society of Cardiovascular Patient Care for accreditation for Stroke Receiving Centers (SRCs). The goal is to have all SRCs accredited by December 2017.	Chris Yoshida-McMath
	3. Stroke Program: Stroke Data	The next Stroke meeting is scheduled on August 7, 2016.	Chris Yoshida-McMath
	4. CQI Report Update	Nothing to report.	Ron Holk
	<ul style="list-style-type: none"> <li>Core Measures</li> </ul>	The 2015 Core Measures were discussed regarding developing strategies for improvement. ICEMA will provide additional information for discussion at future meetings.	Ron Holk
	5. SAC Update	SAC Meeting was cancelled.	Kevin Parkes
	B. EMS Trends		
	1. TXA Study Update	There have been 85 uses of TXA since the beginning of the study; 25 blunt trauma; 2 blunt/penetrating trauma; 54 penetrating trauma; 4 cases were not trauma and did not meet the TXA inclusion criteria.	Chris Yoshida-McMath

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		<p>A total of 7 air cases; all blunt trauma.</p> <p>Data is currently being analyzed by the statistician. To date, there has been no report of adverse effects of TXA in the ICEMA region.</p> <p>Napa County is the process of getting State approval for participation in the TXA study.</p> <p>Alameda County and Riverside County have submitted TXA data. Alameda has 9 TXA administrations since the beginning of the study.</p>	
	2. Paramedicine Step I Research Update	Phase 1 is complete. Phase 2 will include additional training and education.	Reza Vaezazizi
	3. Cardiac Arrest Survival Enhancement Project (CARES/ART)	<p>ART: Nothing to report.</p> <p>CARES: ICEMA and CARES are currently working on a State subscription model of the registry.</p> <p>ICEMA is currently beta testing with AMR Redlands' data. AMR Redlands is currently undergoing training.</p>	Chris Yoshida-McMath
	C. Needle Cricothyrotomy	<p>Several types of needle cricothyrotomy kits were presented.</p> <p>No action at this time. Item will be considered at a future MAC meeting.</p>	All
	D. Excited Delirium	<p>The management of excited delirium patients in the prehospital setting was discussed.</p> <p>ICEMA will review other LEMSA's policies. Item will be considered at a future MAC meeting.</p>	Reza Vaezazizi
	E. Use of Dextrose in Cardiac Arrest	<p>Discussed current verbiage.</p> <p>No action at this time.</p>	Ron Holk
	F. Magnesium Sulfate Dose	<p>Discussed changing Magnesium Sulfate doses for IVP.</p> <p>Change in protocol noted.</p>	Ron Holk
	G. Narcan - Pediatric Route (IN/IM)	<p>Discussed changing Narcan dosing routes to IV, IO and IM.</p> <p>Change in protocol noted.</p>	Ron Holk
	H. ePCR User Interface Task Force	The ePCR User Interface Task Force discussed 12-lead, core measures and capnography, and will continue to work towards solutions.	Ron Holk/Leslie Parham

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V.	PUBLIC COMMENT		All
V.	ROUND TABLE/ ANNOUNCEMENTS		All
VI.	FUTURE AGENDA ITEMS	-Local Optional Scope of Practice	Phong Nguyen
VII.	NEXT MEETING: August 25 , 2016		
VIII.	ADJOURNMENT	Meeting adjourned at 1441.	Phong Nguyen

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Attendees:

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

GUESTS	AGENCY
Sandy Carnes	Rancho Cucamonga FD
Patty Eickholt	SARH
Brent Fuller	Redlands FD
Keith Grubb	SB County FD
Lisa Higuchi	AMR
Jeff Kuhn	
Pam Martinez	Ontario FD
Sara Morning	SB County FD
Miranda Mulhall	SB County FD
Leigh Overton	SB County FD
Henry Perez	Colton FD
Scott Tuttle	SB County FD
Bob Tyson	Redlands FD



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## TRAUMA - ADULT (15 years of age and older)

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

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

### I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

### II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O<sub>2</sub> saturation (if BLS equipped).
- Keep patient warm.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

#### A. Manage Special Considerations

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

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

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

- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.

NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical.

LBB does not need to be reapplied on interfacility transfer (IFT) patients (excludes pediatric patients) who have received cervical spinal clearance by an advanced healthcare provider or physician.

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

**Partial Amputation:** Splint in anatomic position and elevate the extremity.

- **Bleeding:**
  - Apply direct pressure and/or pressure dressing.
  - To control life-threatening bleeding of a severely injured extremity, consider application of tourniquet when direct pressure or pressure dressing fails.
- **Chest Trauma:** If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.
- **Flail Chest:** Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.
- **Fractures:** Immobilize above and below the injury. Apply splint to injury in position found except:
  - **Femur:** Apply traction splint if indicated.

- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**
- **Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.
- **Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15 - 20 degrees), if the patient exhibits no signs of shock.
  - **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe, stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
  - **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.
- **Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.
- **Pregnancy:** Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females  $\geq$  24 weeks of gestation.
- **Traumatic Arrest:** CPR if indicated. May utilize an AED if indicated.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.

### III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway (as indicated).
  - **Unmanageable Airway:** Transport to the closest most appropriate receiving hospital when the patient requires advanced airway and an adequate airway cannot be maintained with a BVM device.
- Apply AED.

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

**Blunt Trauma:**

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

**Penetrating Trauma:**

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

**Isolated Closed Head Injury:**

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

- Transport to appropriate hospital.

**A. Manage Special Considerations**

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

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

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

- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.

NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical.

LBB does not need to be reapplied on interfacility transfer (IFT) patients (excludes pediatric patients) who have received cervical spinal clearance by an advanced healthcare provider or physician.

- **Fractures:**

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

- Administer IV NS 250 ml bolus one (1) time.

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

- **Traumatic Arrest:** Continue CPR as appropriate.

- Apply AED and follow the voice prompts.

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

- *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.

- *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.

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

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
- **Precautions and Comments:**
  - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
  - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.
  - If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.
  - **Unsafe scene may warrant transport despite low potential for survival.**
  - Whenever possible, consider minimal disturbance of a potential crime scene.
- **Base Hospital Orders:** May order additional fluid boluses.

#### IV. ALS INTERVENTIONS

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

#### **Blunt Trauma:**

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

### **Penetrating Trauma:**

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

### **Isolated Closed Head Injury:**

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

- Transport to appropriate hospital.
- Insert nasogastric/orogastric tube as indicated.

### **A. Manage Special Considerations**

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

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

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

**NOTE:** The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical.

LBB does not need to be reapplied on interfacility transfer (IFT) patients (excludes pediatric patients) who have received cervical spinal clearance by an advanced healthcare provider or physician.

- **Chest Trauma:** Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.
  - **Fractures:**
    - **Isolated Extremity Trauma:** Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.
    - **Pain Relief:**
      - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.
      - Consider Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.
      - Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Fentanyl. Administer IV NS 250 ml bolus one (1) time.
  - **Head and Neck Trauma:** Immediately prior to intubation, consider prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.
  - **Base Hospital Orders:** When considering Nasotracheal intubation ( $\geq 15$  years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, Trauma base hospital contact is required.
  - **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.
  - **Traumatic Arrest:** Continue CPR as appropriate.
    - Treat per ICEMA Reference #11070 - Cardiac Arrest - Adult.
- B. Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- *Severe Blunt Force Trauma Arrest:* If indicated, pronounce on scene.
  - *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.

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

## V. REFERENCES

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

**Proposed policy language:**

The long backboard (LBB) is an extrication tool, whose purpose is to facilitate transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization.

Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks.

If a LBB is applied for any reason, patients should be removed as soon as it is safe and practicable.

 Interfacility transfer of patients who have received cervical spine clearance by an advanced healthcare provider or physician do not need to be reapplied to a LBB during transport.

**References:**

*Emergency Nurse's Association. Translation Into Practice, June 2015*

*Massachusetts State EMS policy manual, 2015*

*San Joaquin County EMS Cervical Stabilization Policy 2013*

*Morrissey, J. Research Suggests a Change in Pre-hospital Spinal Immobilization. JEMS 2013*

*NAEMSP Position Statement. EMS Spinal Precautions and the Use of The Long Backboard. 2012*



## Long Backboard Use for Spinal Motion Restriction

**Clinical Significance** Long backboards (LBB) continue to be applied for spinal motion restriction (SMR) in trauma patients despite a lack of substantiated benefits. Judicious use of the LBB necessitates that healthcare providers ensure the benefits of application outweigh the potential risks.

**Populations** Applies to the adult population.

### Translation Into Practice:

#### Recommended Clinical Practice

The LBB is an extrication tool, whose purpose is to facilitate transfer of a patient to a transport stretcher/cart and is not intended or appropriate for achieving SMR.<sup>2,5,6,8-12</sup> [Level A Recommendation]

Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the potential risks.<sup>3,5-8,10-12</sup> [Level A Recommendation]

If an LBB is applied, patients should be removed as soon as it is safe and practicable. This reduces complications, minimizes negative events, and prevents adverse patient outcomes.<sup>3,6-8,10-13</sup> [Level A Recommendation]

It is recommended that individual healthcare facilities develop their own policies, procedures, and guidelines to determine who should remove patients from the LBB and the technique(s) used to do it.<sup>6,8,10</sup> [Level B Recommendation]

Patients being transferred to another facility who have received cervical spine clearance by an advanced practice healthcare provider or physician do not need to be reapplied to an LBB for transport or while awaiting transfer.<sup>3,6-8,10-12</sup> [Level A Recommendation]

It is recommended that all trauma patients receive a spinal assessment whether or not an LBB is used; spinal motion restriction (SMR) is not indicated in all trauma patients.<sup>2-11,14,16</sup> [Level A Recommendation]

Spinal motion restriction in penetrating trauma patients is associated with higher mortality, is unnecessary, potentially hazardous, and not recommended.<sup>2-11</sup> [Level A Recommendation]

Spinal motion restriction should be considered for patients in the following circumstances:<sup>3-6,8-10</sup>

- Blunt trauma and altered level of consciousness
- Spinal deformity, pain, or tenderness
- Focal neurological deficit
- High energy mechanism of injury together with:
  - Alcohol and/or drug intoxication
  - Distracting, painful injury or communication barrier

[Level A Recommendation]

Long Backboard Use for Spinal Motion Restriction

## Long Backboard Use for Spinal Motion Restriction

### Supporting Rationale:

Historically, the long backboard (LBB) was presumed to provide spinal immobilization and stabilization in trauma patients. In fact, prehospital management of trauma patients included application of the LBB as the standard of practice.<sup>1-5</sup> However, the benefits of LBBs have been widely questioned.<sup>2-12</sup> Despite this, it is estimated that millions of patients still receive spinal immobilization each year in the United States, most of whom show no evidence of spinal injuries.<sup>7</sup>

The use of the LBB to immobilize the spine continues despite the lack of supporting scientific evidence.<sup>2-12</sup> While the LBB is a useful extrication tool, its application is not without risks.<sup>3,5-8,10-12</sup> Long backboard use has been shown to cause and lead to the following:<sup>7,8,11,14,15</sup>

- Agitation and anxiety
- Altered physical examination
- Delay in treatment
- Increased cranial pressure
- Pain
- Pressure sores
- Respiratory compromise
- Unnecessary radiographs

Use of the LBB requires judicious consideration of the risks of further complications. Evidence has shown that removal as soon as practicable reduces the probability of complications, adverse outcomes, and negative events.<sup>3,6-8,10-13</sup>

Guidelines for LBB removal may vary depending on staffing, equipment, training, and education. It is recommended that individual healthcare facilities use multidisciplinary teams focusing on the best clinical evidence to develop their own policies, procedures, and guidelines specifying which individuals and what technique(s) would be most effective in safely removing patients from the LBB.<sup>6,8,10</sup>

It is advocated that qualified staff receive the appropriate education, training, and frequent competency evaluations to ensure safe practice and care.<sup>6,8,10</sup>

There is overwhelming support for the view that all trauma patients should receive a spinal assessment whether or not an LBB has been implemented. This is because SMR is not indicated in every trauma patient.<sup>2-14,16</sup> In fact, in penetrating trauma cases, SMR is associated with higher mortality and is universally not recommended.<sup>2-11,16</sup>

Injury prevention measures such as legislation, education, car safety, evidence-based treatment guidelines, and establishment of regional trauma centers, along with medical advances have contributed to increased life expectancies of patients with cervical spinal injuries (CSI) and spinal cord injuries (SCI).<sup>16</sup>

Appropriately applied SMR is acceptable for patients in the circumstances in the bulleted list above (blunt trauma and altered level of consciousness, etc.).<sup>3,4,6-10,12,13,16</sup> However, when clinical assessment for the presence of qualifying SMR injuries cannot be adequately performed, for example, because of communication barriers, it is acceptable to apply SMR in this patient population.<sup>3,4,6-10,12,13,16</sup>

## Long Backboard Use for Spinal Motion Restriction

### References

- Domeler, R. M. (1999). Indications for prehospital spinal immobilization. *Prehospital Emergency Care*, 3(3), 251–253. Retrieved from <http://www.naemsp.org/Documents/Position%20Papers/POSITION%20IndicationsforSpinalImmobilization.pdf>
- Oteir, A. D., Smith, K., Stoelwinder, J. U., Middleton, J., & Jennings, P. A. (2015). Should suspected cervical spinal cord injury be immobilised? A systematic review. *Injury*, 46(4), 528–535. doi:10.1016/j.injury.2014.12.032
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### Key for Level of Evidence Recommendation

 <b>Level A (High) Recommendation:</b>	Based on consistent and good quality of evidence, has relevance and applicability to emergency nursing practice.	 <b>Not Recommended:</b>	Based upon current evidence.
 <b>Level B (Moderate) Recommendation:</b>	There are some minor inconsistencies in quality evidence, has relevance and applicability to emergency nursing practice.	I/E:	Insufficient evidence upon which to make a recommendation.
 <b>Level C (Weak) Recommendation:</b>	There is limited or low quality patient oriented evidence, has relevance and applicability to emergency nursing practice.	N/E:	No evidence upon which to make a recommendation.

### Disclaimer

This document, including the information and recommendations set forth herein (i) reflects ENA's current position with respect to the subject matter discussed herein based on current knowledge at the time of publication; (ii) is only current as of the publication date; (iii) is subject to change without notice as new information and advances emerge; and (iv) does not necessarily represent each individual member's personal opinion. The information and recommendations discussed herein are not codified into law or regulations. Variations in practice and practitioners' best nursing judgment may warrant an approach that differs from the recommendations herein. ENA does not approve or endorse any specific sources of information referenced. ENA assumes no liability for any injury and/or damage to persons or property arising from the use of the information in this document.

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## MEDICATION - STANDARD ORDERS

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**Medications listed in this protocol may be used only for the purposes referenced by the associated ICEMA Treatment Protocol. Any other use, route or dose other than those listed, must be ordered in consultation with the Base Hospital physician.**

### **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, 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)**

*Chest Pain (Presumed Ischemic Origin):*

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, 10190, 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, 10190, 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, 10190*

**Magnesium Sulfate (ALS)**

*Polymorphic Ventricular Tachycardia:*

Magnesium Sulfate, 2 gm ~~in 100 ml of NS~~ IV/IO bolus 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~~ 10 mg/min IV/IO drip 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, 10190, 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, 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/ <u>IM/IN</u>
9 to 14 years	Naloxone, 0.5 mg IV/IO/ <u>IM/IN</u>

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*

**Oxygen (non-intubated patient per appropriate delivery device)***General Administration (Hypoxia):*

Titrate Oxygen at lowest rate required to maintain SPO<sub>2</sub> at 94%.

Do not administer supplemental oxygen for SPO<sub>2</sub> > 95%

*Chronic Obstructive Pulmonary Disease (COPD):*

Titrate Oxygen at lowest rate required to maintain SPO<sub>2</sub> at 90%

Do not administer supplemental oxygen for SPO<sub>2</sub> > 91%

*Reference #s 6140, 9010, 9120, 11010, 11020, 11040, 11050, 11060, 11080, 11090, 11100, 13010, 13020, 13030, 14010, 14020, 14030, 14050, 14060, 14070, 14080, 14090, 15010, 15020*

**Phenylephrine HCL (ALS)**

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

*Reference #s 7010, 7020, 10050, 10190*

**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) (base hospital order only)**

*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*



## FORT IRWIN CONTINUATION OF ~~TRAUMA~~ CARE

~~THIS POLICY IS FOR FORT IRWIN FIRE DEPARTMENT (FIFD), FORT IRWIN DEPARTMENT OF EMERGENCY SERVICES (DES), FORT IRWIN ARMY AIR AMBULANCE AND WEED ARMY COMMUNITY HOSPITAL (WACH) FOR TRANSPORTATION AND TRANSFER OF STEMI, STROKE OR TRAUMA PATIENTS TO A TRAUMA CENTER OR SPECIALTY CARE CENTER ONLY AND SHALL NOT BE USED FOR ANY OTHER TRANSFERS OR REQUESTS FOR TRANSFER FROM OTHER FACILITIES. THIS POLICY IS FOR FORT IRWIN/WEED ARMY HOSPITAL TRANSPORT/TRANSFER OF TRAUMA PATIENTS TO A TRAUMA CENTER ONLY AND SHALL NOT BE USED FOR ANY OTHER REQUESTED TRANSFERS FROM OTHER FACILITIES.~~

### I. PURPOSE

~~To provide a mechanism of rapid transport of STEMI, stroke, or trauma patients from within the boundaries of Fort Irwin and the National Training Center to an appropriate STEMI, stroke, or trauma center for higher level of care with minimal delay. The terrain and nature of the National Training Center at Fort Irwin presents particular obstacles for the transport of STEMI, stroke, or trauma patients. Most STEMI, stroke, or trauma patients must be airlifted to an appropriate Specialty Care Center. To provide a mechanism of rapid transport of trauma patients from Fort Irwin and Weed Army Hospital to an appropriate trauma hospital for higher level of care with minimal delay.~~

#### ~~1. FIELD TO TRAUMA HOSPITAL~~

- ~~a. The terrain and nature of the Army National Training Facility at Fort Irwin presents particular obstacles to the transport of trauma patients. Most trauma patients must be airlifted to appropriate treatment facilities. To expedite appropriate treatment, trauma patients from Fort Irwin may be airlifted directly to the most appropriate Trauma Hospital, in accordance with ICEMA Protocol #15030 Trauma Triage Criteria and Destination Policy.~~
- ~~b. ICEMA accredited paramedics will follow ICEMA Trauma Protocols #15010 and #15020.~~
- ~~c. The assigned base hospital for medical control will be Loma Linda University Medical Center (LLUMC).~~

- ~~d. Requests for air ambulances shall be made through County Communications Center (CCC). Trauma hospital destination will be rotated by the CCC in accordance with ICEMA Protocol #8070.~~
- ~~e. If LLUMC is not the receiving facility, the medic will attempt to inform Arrowhead Regional Medical Center (ARMC) of the incoming trauma patient.~~

~~2. WEED ARMY HOSPITAL TO TRAUMA HOSPITAL~~

~~a. INITIAL TREATMENT GOALS~~

- ~~• Initiate resuscitative measures within the capabilities of the facility.~~
- ~~• Prepare patient for transport.~~
- ~~• Contact CCC for air ambulance rotation and trauma hospital destination.~~
- ~~• **DO NOT DELAY TRANSFER** by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.~~
- ~~• Weed Army Hospital ED Physician will make direct physician-to-physician contact with the ED physician at the Trauma Center.~~
- ~~• The Trauma Center will accept all referred trauma patients unless the hospital is on Internal Disaster Diversion (Reference ICEMA Protocol #8060).~~
- ~~• The Trauma Center ED physician is the accepting physician at the Trauma Center and will activate the Trauma Team according to internal Trauma Center protocols.~~
- ~~• Weed Army Hospital must send all medical records, test results, radiologic evaluations to the Trauma Center. **DO NOT DELAY TRANSFER** these documents may be FAXED to the Trauma Center.~~

II. POLICY

1. Weed Army Community Hospital (WACH) to a STEMI Receiving Center (SRC), Neurovascular Stroke Center (NRSC) or Trauma Center (TC).

a. PATIENT INCLUSION CRITERIA

- Any patient meeting ICEMA Trauma Triage Criteria, (refer to ICEMA Reference #15030 - Trauma Triage Criteria and #8130 - Destination Policy) arriving at a non-trauma hospital by EMS or non-EMS transport.

- Any patient with a positive STEMI requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy).
- Any patient with a positive mLAPSS or stroke scale requiring EMS transport to a NSRC (refer to ICEMA Reference #6100 - Neurovascular Stroke Receiving Centers Destination Policy).
- These procedures are not to be used for any other form of interfacility transfer of patients.

b. INITIAL TREATMENT GOAL AT WACH

- Initiate resuscitative measures within the capabilities of the hospital.
- Ensure patient stabilization is adequate for subsequent transport.
- DO NOT DELAY TRANSPORT by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.
- WACH ED physician will determine the appropriate mode of transportation for the patient. WACH will contact Fort Irwin Army MEDEVAC for air ambulance transport utilizing established procedures for Fort Irwin.
- GUIDELINES:
  - < 30 minutes at WACH (door-in/door-out).
  - < 45 minutes to complete continuation of care transport.
  - < 30 minutes door-to-intervention at Specialty Care Center.
- WACH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. WACH will contact the assigned Specialty Care Center in accordance with ICEMA Policy #8120 - Continuation of Care (San Bernardino County Only).

SRC: Desert Valley Hospital, St. Mary Medical Center

NSRC: Loma Linda University Medical Center, Arrowhead Regional Medical Center

TC: Loma Linda University Medical Center, Arrowhead Regional Medical Center

- WACH ED physician will provide a verbal report to the ED physician at the Specialty Care Center.
- Fort Irwin Army MEDEVAC will make Specialty Care Center base hospital contact.
- Specialty Care Centers shall accept all referred STEMI, stroke, or trauma patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).
- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal STEMI, Stroke, or Trauma Team according to internal SRC, NSRC or TC policies or protocols.

WACH must send all medical records, test results and radiologic evaluations to the Specialty Care Center. DO NOT DELAY TRANSPORT - these documents may be FAXED to the Specialty Care Center.

c2. SPECIAL CONSIDERATIONS

- a. ~~If the patient has arrived at Weed Army Hospital via EMS, the Weed Army Hospital ED physician may request the transporting team to remain with the patient and immediately transport once the minimal stabilization is done at Weed Army Hospital.~~
- b. ~~Weed Army Hospital may consider sending one of its nurses with the transporting unit if deemed medically necessary.~~
- c. ~~Paramedics may transport patients on Dopamine, Lidocaine and Procainamide drips only. Unless medically necessary, avoid using medication drips that are outside the paramedic scope of practice to avoid any delay in transferring trauma patients.~~
- If a suspected stroke patient is outside of the tPA administration window (greater than 4.5 hours from “last seen normal”), contact nearest NSRC to determine the best destination.
- ICEMA EMT-Ps may only transport patients on Dopamine, Lidocaine and Procainamide drips. Heparin and Integriillin drips are not within the ICEMA EMT-P scope of practice.

- WACH should consider sending one of its nurses, or a physician, with the Fort Irwin Army MEDEVAC if deemed necessary due to the patient's condition or scope of practice. This practice is highly encouraged. US Army Flight Medics and Critical Care Flight Paramedics may request additional providers from WACH upon its assessment of the patient's condition and en route care needs.
- Specialty Care Center diversion is not permitted except for Internal Disaster. However, Specialty Care Center base hospitals are allowed to facilitate redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to minimize door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

## 2. AIR AMBULANCE

- Fort Irwin maintains internal 24-hour US Army Air Ambulance with MEDEVAC capabilities conducted by C Company (Air Ambulance), 2916<sup>th</sup> Aviation Battalion. Fort Irwin Army Air Ambulance is the primary method of air transport for medical and trauma patients originating within the boundaries of the National Training Center and Fort Irwin. Requests for use of this asset by Fort Irwin Range Control, DES, FIFD and WACH will be in accordance with the procedures established within Fort Irwin. To expedite appropriate treatment of STEMI, stroke, or trauma patients, Fort Irwin Army Air Ambulance will proceed directly to the most appropriate SRC, NSRC or TC, for patients that meet the criteria of ICEMA Reference #15030 - Trauma Triage Criteria, #8120 - Continuation of Care and #8130 - Destination Policy when immediate lifesaving intervention or stabilization is not required. These patients will bypass WACH and proceed directly to a SRC, NSRC or TC for treatment.
- Fort Irwin Army Air Ambulance will contact the County Communication Center (CCC) for TC destination. TC destination will be rotated by the CCC in accordance with ICEMA Reference #8070 - Aircraft Rotation Policy (San Bernardino County Only). If unable to contact the CCC, Fort Irwin Army MEDEVAC will follow the destination policy established in ICEMA Reference #8130 - Destination Policy.
- The assigned base hospital for medical control will be Loma Linda University Medical Center (LLUMC). ICEMA EMT-Ps will follow ICEMA's policies, procedures and protocols. US Army Flight Medics and Critical Care Flight Paramedics will follow the Standard Medical Operating Guidelines (SMOG) established by the US Army Surgeon General and the assigned US Army Flight Surgeon. When conflicts in procedure or protocol

of patient care exists between ICEMA and the US Army SMOG, each EMS provider will work in accordance with its individual protocols and confer jointly to assure the best possible care is provided and achieves the best outcome for the patient. US Army Flight Medics and Critical Care Flight Paramedics are authorized to perform all treatments and procedures that are provided as en route medical orders from the receiving hospital or the medical direction of LLUMC.

- d. The onboard attending FIFD ICEMA EMT-P will make contact with the destination SRC, NSRC or TC prior to arrival in order to alert the STEMI, Stroke, or Trauma Teams. In the absence of the FIFD ICEMA EMT-P, the US Army Flight Medic or US Army Critical Care Flight Paramedic will ensure contact is made in accordance with Fort Irwin's procedures.
- e. In the event of special considerations, such as weather, time, distance and patient location, the Fort Irwin Army Air Ambulance Pilot-in-Command may choose to divert to University Medical Center (UMC) Las Vegas in accordance with the Memorandum of Agreement established between Fort Irwin Army Air Ambulance and UMC Las Vegas.
- f. In times of inclement weather or due to aircraft emergencies where landing at the destination hospital is not feasible, Fort Irwin MEDEVAC will contact the CCC for assistance in order to arrange for ground ambulance transportation at an appropriate airfield or the precautionary landing zone so that transportation of the patient can continue to the designated hospital.
- g. Should Fort Irwin Army Air Ambulance be unavailable for patient transportation, requests for civilian air ambulance support shall be made through the CCC by FIFD or WACH.

### 3. GROUND AMBULANCE

- a. Ground ambulances on Fort Irwin are provided and staffed by WACH and are dispatched by Fort Irwin DES with support from FIFD.
- b. Patients that are determined to meet ICEMA's Trauma Triage Criteria (refer to ICEMA Reference #15030 - Trauma Triage Criteria) or are in immediate need of a Specialty Care Center as determined by a FIFD ICEMA EMT-P may be transported directly to the Fort Irwin Main Post Helipad or designated ambulance exchange point for immediate transfer by air ambulance when immediate lifesaving intervention or stabilization is not required. These patients will bypass WACH and proceed directly to a SRC, NSRC or TC for treatment. Coordination for this exchange will be conducted by FIFD utilizing established procedures to contact Fort Irwin Army MEDEVAC.

- c. Patients that do not meet ICEMA's Trauma Triage Criteria or require immediate lifesaving interventions or stabilization will be transported directly to WACH.

III. REFERENCES

<u>Number</u>	<u>Name</u>
6070	<u>Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy</u>
6100	<u>Neurovascular Stroke Receiving Centers Destination Policy (San Bernardino County Only)</u>
8060	<u>Requests for Hospital Diversion Policy (San Bernardino County Only)</u>
8070	<u>Aircraft Rotation Policy (San Bernardino County Only)</u>
8120	<u>Continuation of Care (San Bernardino County Only)</u>
8130	<u>Destination Policy</u>
15030	<u>Trauma Triage Criteria</u>



## GENERAL PATIENT CARE GUIDELINES

### I. PURPOSE

To ~~provide~~establish guidelines for ~~providing~~ the minimum standard of care and transport ~~for all of~~ patients ~~contacts~~.

### AUTHORITY

~~California Health and Safety Code, Title 22, Division 9, Chapter 4, Sections 100145, 100146 and 100147.~~

### II. DEFINITIONS

**Patient:** An individual with a complaint of pain, discomfort or physical ailment. An individual regardless of complaint, with signs and/or symptoms of pain, discomfort, physical ailment or trauma. These signs ~~/or~~ symptoms include, but are not limited to:

1. Altered level of consciousness.
2. ~~Sign and/or symptoms of s~~keletal or soft tissue injuries.
3. Acute or chronic injury or disease process.
34. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
45. Evidence that the individual was subject to ~~significant~~ force that may cause injury.
6. Other condition that warrants evaluation and care at an acute care hospital.

**Patient Contact:** Determined to ~~be achieved~~occur when any on duty BLS, LALS, or ALS field ~~personnel~~provider (EMT, AEMT, EMT-P, RN) comes into the presence of a patient as defined above.

### III. BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
  - a. Airway, breathing and circulatory status.
  - b. Subjective assessment of the patient's physical condition and environment.

- c. Objective assessment of the patient's physical condition and environment.
  - d. Vital signs (blood pressure, pulse, respiration, GCS, skin signs, etc.).
  - e. Prior medical history and current medications.
  - f. Any known medication allergies or adverse reactions to medications, food or environmental agents.
2. Initiate care using the following tools as clinically indicated or available:
    - a. Axial spinal immobilization.
    - b. Airway control with appropriate BLS airway adjunct.
    - c. Oxygen as clinically indicated.
    - d. Assist the patient into a physical position that achieves the best medical benefit and maximum comfort.
    - e. Automated External Defibrillator (AED).
    - f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated.
  3. Assemble necessary equipment for ALS procedures or treatment under direction of EMT-P.
    - a. Cardiac monitoring.
    - b. IV/IO.
    - c. Endotracheal intubation.
  4. Under EMT-P supervision, assemble pre-load medications as directed, ~~(excluding~~ (excluding controlled substances).

#### IV. LIMITED ALS (LALS) INTERVENTIONS

1. Evaluation and continuation of all initiated BLS care ~~initiated~~.
2. Augment BLS assessment with an advanced assessment including, but not limited to the following:
  - a. Qualitative lung assessment.
  - b. Blood glucose monitoring.

3. Augment BLS treatment measures with LALS treatments as indicated by LALS protocols.
4. Initiate airway control as needed with the appropriate LALS adjunct.
5. Initiate vascular access as clinically indicated.

## V. ALS INTERVENTIONS

1. Evaluation and continuation of all initiated BLS and/or LALS care when indicated by patient's condition. ~~initiated.~~
2. Augment BLS and/or LALS assessment with ~~a clinically indicated~~ advanced assessments including but not limited to the following:  
  
~~Qualitative lung assessment.~~
  - a. Cardiac monitor ~~and/or 12-lead ECG.~~
  - a.b. Capnography.
  - b.c. Blood glucose monitoring.
3. Augment BLS and/or LALS treatment with advanced treatments as clinically indicated ~~indicated or available.~~
  - a. Initiate airway control ~~as needed using an appropriate airway adjunct to achieve adequate oxygenation and ventilation with the appropriate ALS adjunct.~~
  - b. Initiate vascular access ~~as only when~~ clinically indicated for the appropriate administration of medications and/or fluids.
4. Review and evaluate treatments initiated by BLS, LALS, or ALS providers.
  - a. Consider discontinuing treatments not warranted by patient's clinical condition. Intermittent monitoring may be used instead of continuous monitoring when clinically indicated.



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## DETERMINATION OF DEATH ON SCENE

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### I. PURPOSE

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

### II. POLICY

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

- ~~• The EMT-P is authorized to discontinue BLS CPR initiated at the scene if a patient meets determination of death criteria.~~
- ~~• If any ALS procedures are initiated, only the base hospital physician/designee may determine death in the field.~~
- ~~• In any situation where there may be doubt as to the clinical findings or validity of the patient's end of life directives, BLS CPR must be initiated and the base hospital contacted.~~
- ~~• When death is determined, the County Coroner must be notified.~~
- ~~• If the patient does not meet the Determination of Death Criteria, appropriate interventions must be initiated.~~
- ~~• Resuscitation efforts shall not be terminated en route. The patient will be transported to the closest facility where determination of death will be made.~~
- ~~• Victims of electrocution, lightning and drowning should have resuscitative efforts begun and transported to an appropriate receiving hospital.~~
- ~~• Hypothermic patients should be treated per ICEMA Reference #13030 - Cold Related Emergencies, under Severe Hypothermia.~~

### III. DETERMINATION OF DEATH CRITERIA

An EMT, AEMT or EMT-P may determine death on scene if the patient is pulseless and apneic with any of the following:

- A patient with multiple signs of death and/or prolonged lifelessness including:
  - Decomposition
  - Obvious signs of rigor mortis such as rigidity or stiffening of muscular tissues and joints in the body, which occurs any time after death and usually appears in the head, face and neck muscles first.
  - Obvious signs of venous pooling in dependent body parts, lividity such as mottled bluish-tinged discoloration of the skin, often accompanied by cold extremities.
- Obvious Death
  - Decapitation.
  - Incineration of the torso and/or head.
  - Massive crush injury.
  - Penetrating injury with evisceration~~destruction~~ and/or separation of major organs (~~the~~ heart, liver, and/or brain).
  - Gross dismemberment of the trunk.
  - Pulseless and apneic with injury not compatible with life.
- Severe Blunt Force Trauma
  - Absent signs of life (palpable pulses and/or spontaneous respirations) and cardiac electrical activity less than 40 bpm or throughout EMS patient assessment.
- Declared Multiple Casualty Incident (MCI)
  - Pulseless, apneic, or agonal patient where triage principles and available resources preclude initiation of resuscitation.
- Standardized Patient Designated Directives/End of Life Options Act Directive

➤ Pulseless, apneic or agonal patient with valid end of life directive.

➤ ICEMA Reference #12020 - End of Life Care and Decisions.

## PROCEDURE

- ~~If the patient does not meet the Determination of Death criteria, appropriate interventions must be initiated.~~
- ~~Resuscitation efforts shall not be terminated en route per Government Code 27491. The patient will be transported to the closest facility where determination of death will be made by hospital staff.~~
- ~~Most victims of electrocution, lightning and drowning should have resuscitative efforts begun and transported to the appropriate Hospital/Trauma Center.~~
- ~~Hypothermic patients should be treated per ICEMA Reference #13030—Cold Related Emergencies, under Severe Hypothermia.~~
- ~~A DNR report form must be completed, if applicable, refer to ICEMA Reference #12020—Withholding Resuscitative Measures.~~
- ~~**San Bernardino County Only:**~~
  - ~~A copy of the patient care report must be made available for the Coroner. This will be transmitted to them, when posted, if the disposition is marked “Dead on Scene” and the Destination is marked “Coroner, San Bernardino County” on the electronic patient care report (ePCR). If unable to post, a printed copy of the ePCR, OIA or a completed *Coroners Worksheet of Death* must be left at the scene. The completed ePCR or OIA must be posted or faxed to the Coroner before the end of the shift.~~

## ~~LIMITED ALS (LALS) PROCEDURE~~

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

## ~~ALS PROCEDURE~~

- All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the base hospital physician/designee.

- ~~• Severe blunt force trauma, pulseless, without signs of life (palpable pulses and/or spontaneous respirations) and cardiac electrical activity less than 40 bpm or during EMS encounter with the patient meets Determination of Death criteria.~~
- All terminated ALS resuscitation efforts must have an ECG attached to the ~~patient care report~~PCR.
- ~~— All conversations with the base hospital must be fully documented with the name of the base hospital physician who determined death, times and instructions on the patient care report.~~
- **Coroner Notification (San Bernardino County Only)**
  - A copy of the ePCR must be made available for the Coroner. This will be transmitted to them, when posted, if the disposition is marked “Dead on Scene” and the Destination is marked “Coroner, San Bernardino County” on the ePCR.
  - If unable to post, a printed copy of the ePCR or a completed Coroners Worksheet of Death must be left at the scene. The completed ePCR must be posted and/or faxed to the Coroner as soon as possible but within four (4) hours of the initiation of the call.

#### IV. SUSPECTED SUDDEN INFANT DEATH SYNDROME (SIDS) INCIDENT

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

##### PROCEDURE

- Follow individual department/agency policies at all times.
- Ask open-ended questions about incident.
- Explain what you are doing, the procedures you will follow, and the reasons for them.
- If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
- Provide the parent/caregiver with the number of the California SIDS Information Line: **1-800-369-SIDS (7437)**
- Provide psychosocial support and explain the emergency treatment and transport of their child.

- Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.
- Document observations.

**V. REFERENCES**

<u>Number</u>	<u>Name</u>
12020	<del>Withholding Resuscitative Measures</del> <u>End of Life Care and Decisions</u>
<del>13030</del>	<del>Cold Related Emergencies</del>



## WITHHOLDING RESUSCITATIVE MEASURES END OF LIFE CARE AND DECISIONS

### I. PURPOSE

To establish criteria that recognizes and accommodates a patient's wish-designated end of life directives to limit prehospital treatment by Emergency Medical Service (EMS) field personnel who do not otherwise meet the "Determination of Death" criteria in the prehospital setting, ~~or~~ long-term care facilities, during transport between facilities and/or in the patient's homes.

### ~~II. POLICY~~

~~The Do Not Resuscitate (DNR) only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement. The forms (see Appendix) that may be used are:~~

- ~~• The statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital Do Not Resuscitate form.~~
- ~~• The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) form.~~
- ~~• A standard EMSA/ICEMA approved DNR medallion.~~
- ~~• A Do Not Resuscitate Order in a patient's chart dated and signed by the physician.~~

### III. DEFINITIONS

Absent Vital Signs: Absence of respiration and absence of carotid pulse.

Aid-In-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, who may choose to self-administer to bring about their death due to a terminal disease.

Advanced Directive: The California Advance Health Care Directive is a legal document in which a person specifies what actions should be taken for their health if they are unable to make decisions for themselves because of illness or incapacity. Advanced Directives may include:

- Power of Attorney for healthcare.

- Individual instructions for healthcare and/or organ donation in the event that the patient is unable to speak for themselves.
- Signatures and witnessing provisions.

**Cardiopulmonary Resuscitation (CPR):** Interventions intended to restore cardiac activity and respirations that include chest compressions, rescue breathing, and defibrillation.

**Do Not Resuscitate (DNR):** A written order by a physician or the presence of a DNR medallion/bracelet or necklace indicating that an agreement has been reached between the physician and patient/or surrogate that in the event of cardiac or respiratory arrest the following medical interventions will **NOT** be initiated:

- Chest compressions
- Defibrillation
- Endotracheal intubation
- Assisted ventilation
- Cardiotoxic drugs, e.g., Epinephrine, Atropine or other medications intended to treat a non-perfusing rhythm.

~~**Absent Vital Signs:** Absence of respiration and absence of carotid pulse.~~

**DNR Medallion/Bracelet/Necklace:** A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA). There are currently only three (3) ~~two (2)~~ approved medallion providers/vendors for California that produce the DNR medallions and bracelets. They are StickyJ Medical ID, MedicAlert Foundation and Caring Advocates.

**End of Life Option Act:** A California law that authorizes an adult, eighteen years of age or older, who satisfies certain conditions to request an “aid-in-dying drug” prescribed for the purpose of ending their life in a humane and dignified manner.

**EMS Prehospital Do Not Resuscitate (DNR) Form:** Form developed by the California Medical Association (CMA) for use statewide for prehospital DNR requests. This form has been approved by EMSA and ICEMA. This form should be available to EMS field personnel in the form of the white original DNR form or as a photocopy. The original or copy of the DNR form will be taken with the patient during transport. **The DNR form shall not be accepted if amended or altered in any way.**

~~**EMS Field Personnel:** Any EMS field responder currently certified and/or accredited in San Bernardino, Inyo or Mono Counties.~~

**Physician Orders for Life-Sustaining Treatment (POLST):** A physician's order that outlines a plan of care reflecting the patient's wishes concerning care at life's end. The POLST form is voluntary and is intended to assist the patient and ~~their~~ family with planning ~~and developing a plan to that~~ reflect the patient's end of life wishes. It is also intended to assist physicians, nurses, health care facilities and EMS field personnel in honoring a person's wishes for life-sustaining treatment.

EMS field personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

The POLST complements an Advance Directive and is not intended to replace that document.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate patient's wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide EMSA/California Medical Association (CMA) Prehospital DNR Form, (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-Approved DNR Medallion

Supportive Measures: Medical interventions used to provide and promote patient comfort, safety, and dignity. Supportive measures may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhage control
- Oral hydration
- Glucose administration
- Pain control (i.e., Fentanyl)

### III. POLICY

EMS field personnel shall make all attempts to honor a patient's end of life wishes. In doing so, all efforts should be made to obtain and verify applicable forms describing the patient's end of life instructions and provide any necessary supportive measures.

A Do Not Resuscitate (DNR) order only applies to resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatments, nutrition or supportive measures. The treatment given to a patient with a DNR agreement should, in all respects, be the same as that provided to a patient without such an agreement.

A patient with medical decision making capacity can request alternative treatment or revoke a DNR or POLST by any means that indicates intent to revoke. A patient may withdraw or rescind their request for an aid-in-dying drug regardless of their mental state at any time.

~~The Do Not Resuscitate (DNR) only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement. The forms related to patient's end of life instructions (see Appendix) that EMS field personnel may encounter include be used are:~~

- ~~• The statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Do Not Resuscitate form.~~
- ~~• The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) form.~~
- ~~• A standard EMSA/ICEMA approved DNR medallion, bracelet or necklace.~~
- A Do Not Resuscitate Order in a patient's chart dated and signed by the physician.
- ~~• End of Life Options Act Directive and/or Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner form.~~

#### IV. VALIDATION CRITERIA

##### EMS Prehospital DNR

- The EMS ~~Statewide~~ Prehospital DNR form should include the following to be considered valid:
  - Patient's name.
  - Signature of the patient or a legally recognized decision maker if the patient is unable to make or communicate informed health care decisions.
  - Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
  - All signatures ~~are to~~ must be dated.
  - Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.

- In licensed healthcare facilities a DNR order written by a physician shall be honored.
  - The staff must have the patient’s chart with the DNR order immediately available for EMS field personnel upon their arrival.
  - The order may contain the words Do Not Resuscitate, No CPR, or No Code and contain the patient’s name and the date and signature of the physician.

### DNR Medallion, Bracelet or Necklace

- The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:

- Patient must be physically wearing the DNR medallion/ bracelet/necklace.
- Medallion/bracelet/necklace must be engraved with the words “Do Not Resuscitate EMS” or California POLST EMS”, along with a toll free emergency information telephone number and a patient identification number.



### Physician Order for Life Saving Treatment (POLST)

- The POLST does not replace the Advanced Directive and should be reviewed along with other documents when available. The POLST:
  - Must be signed and dated a physician, nurse practitioner or physician assistant acting under the supervision of a physician and within the scope of practice authorized by law.
  - Must be signed by the patient or decision maker.
  - Is not valid without signatures. Verbal or telephone orders are acceptable with follow-up signature by the physician in accordance with facility/community policy. There should be a box checked indicating who the physician-authorized health care provider discussed the POLST orders with. By signing the form, the healthcare provider acknowledges that these orders are consistent with the patient’s medical condition and preferences.

### End of Life Options Act Directive

- A terminally ill and competent patient may elect to obtain medications to hasten their imminent death at a time and place of their choosing. They must satisfy extensive and stringent requirements as required by California law to obtain an Aid-In-Dying Drug and complete a “Final Attestation For An Aid-In-Dying Drug

to End My Life in a Humane and Dignified Manner” within 48 hours prior self-administration.

- There are no standardized “Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” forms but the law has required specific information that must be in the final attestation. If available, EMS field personnel should make a good faith effort to review and verify that the final attestation contains the following information:
  - The document is identified as a “Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner”.
  - Patient’s name, signature and dated.
  - EMS providers should review and verify that the “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” is present.
  - correctly identifies the patient’s name and is signed and dated by the patient or designated decision maker.
  - The Final Attestation for An Aid-In-Dying Drug must be completed within 48 hours prior to taking the medications.
  - Obtain a copy of the final attestation and attach it to the ePCR form whenever possible.
  - There is no mandate for the patient to maintain the final attestation in close proximity of the patient.
  - If a copy of the final attestation is available, EMS field personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.
- ~~The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:~~
  - ~~Patient must be physically wearing the DNR medallion/ bracelet/necklace.~~
  - ~~Medallion/bracelet/necklace must be engraved with the words “Do Not Resuscitate EMS”, along with a toll free emergency information telephone number and a patient identification number.~~
- ~~In licensed healthcare facilities a DNR order written by a physician shall be honored. The staff must have the patient’s chart with the DNR order immediately available for EMS field personnel upon their arrival. The order may contain the words Do Not Resuscitate, No CPR, or No Code and contain the patient’s name and the date and signature of the physician.~~
- ~~The POLST form must be signed and dated by a physician. Without this signature, the form is invalid. Verbal or telephone orders are valid if allowed by the institution or facility. There should be a box checked indicating who the~~

~~physician discussed the POLST orders with. By signing the form, the physician acknowledges that these orders reflect the wishes of the patient or designated decision maker.~~

- ~~• Advanced Health Care Directives that include a signed DNR or POLST form.~~

## V. PROCEDURE

### DNR, Medallion/Bracelet/Neckless or POLST

In addition to the validation criteria, the following guidelines are provided for EMS field personnel when responding to a patient with Standardized Patient-Designated Directives.

- EMS field personnel shall validate the DNR request, medallion/bracelet/necklace, or POLST form. Patient may withdraw any directive at any time.
- The POLST may be used for both adults and pediatric patients.
- BLS field personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.
- LALS and ALS field personnel shall contact a base hospital for direction if a DNR or POLST cannot be validated or for conflicting requests by family members. While ALS field personnel are contacting the base hospital for direction, BLS treatment must be initiated and continued. If contact cannot be made, resuscitative efforts shall continue.
- If a patient states that they wish resuscitative measures, the request shall be honored.
- If a family member requests resuscitative measures despite a valid DNR or POLST, continue resuscitative measures until base hospital contact is made.
- If patient is not in cardiac arrest and has a valid POLST form, EMS field personnel may provide comfort measures as described in Section B of the form.
- The patient shall be transported to the hospital if comfort measures are started by EMS field personnel.
- Direct any questions or conflicts in about transporting the patient to the base hospital.
- EMS field personnel shall attach a copy of the approved DNR form or POLST form to the patient care record, along with any other appropriate written documentation. The DNR form should accompany the patient to the hospital so that it may be incorporated into the medical record at the receiving facility.

- When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician's name. It should be noted on the patient care record that a written DNR order was present including the name of the physician, date signed and other appropriate information.
- All circumstances surrounding the incident must be documented on the EMS patient care report. If EMS field personnel are unable to copy the DNR or POLST form, the following shall be documented on the patient care report:
  - Presence of DNR or POLST form.
  - Date of order.
  - Name of physician who signed form.
- If a patient ~~dies~~ expires at home, and the patient is not under the care of Hospice, law enforcement must be notified ~~unless patient is under the care of Hospice~~. In all cases, the coroner must be notified. Refer to ICEMA Reference #12010 - Determination of Death On Scene.
- If a patient expires in a licensed healthcare facility, the facility has the responsibility to make the appropriate notification.

### **End of Life Options Act**

In addition to the validation criteria, the following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

- The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients.
- Provide supportive measures whenever possible.
- Withhold resuscitative measures if patient is in cardiopulmonary arrest.
- The patient may withdraw or rescind their request for an aid-in-dying drug regardless of the patient's mental state at any time. EMS field personnel are encouraged to consult with their base hospital whenever necessary.
- Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If conflict arises as to resuscitation efforts, inform the family that only supportive measures will be provided according to the patient's wishes and consider Base Hospital contact to attempt resolution.
- All circumstances surrounding the incident must be documented on the EMS patient care report. If EMS field personnel are unable to obtain a copy of the End

of Life Options Act Final Attestation form, the following shall be documented on the patient care report:

- Presence of the End of Life Options Act Attestation form.
- Date of order.
- Name of physician who signed form.
  
- If a patient dies at home and the patient is not under the care of Hospice, law enforcement must be notified. In all cases, the coroner must be notified. Refer to ICEMA Reference #12010 Determination of Death On Scene.
  
- If a patient expires in a licensed healthcare facility, the facility has the responsibility to make the appropriate notification.

## VI. SUPPORTIVE MEASURES

- Medical interventions and/or treatment that may provide for the comfort, safety and dignity of the patient should be utilized.
  
- The patient should receive palliative treatment for pain, dyspnea, major hemorrhage or other medical conditions.
  
- Allow any family members/significant others to express their concerns and begin their grieving process.
  
- Unless a patient is actively dying, medical treatment for other conditions should not be withheld.

**VII. APPENDIX**

**~~The Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital Do Not Resuscitate form.~~**



CMA PUBLICATIONS 1(800) 882-4262 WWW.CMAAET.ORG

**EMERGENCY MEDICAL SERVICES  
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM**



**PURPOSE**

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel regarding a patient's decision to forego resuscitative measures in the event of cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotoxic drugs. This form does not affect the provision of life sustaining measures such as artificial nutrition or hydration or the provision of other emergency medical care, such as palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

**APPLICABILITY**

This form was designed for use in prehospital settings --i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed request regarding resuscitative measures, including a Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion), from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

**INSTRUCTIONS**

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by the patient's legally recognized health care decisionmaker if the patient is unable to make or communicate informed health care decisions. The legally recognized health care decisionmaker should be the patient's legal representative, such as a health care agent as designated in a power of attorney for health care, a court-appointed conservator, or a spouse or other family member if one exists. The patient's physician must also sign the form, affirming that the patient/legally recognized health care decisionmaker has given informed consent to the DNR instruction.

The white copy of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion—see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The goldenrod copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The pink copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

**REVOCATION**

In the absence of knowledge to the contrary, a health care provider may presume that a request regarding resuscitative measures is valid and unrevoked. Thus, if a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

*Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.*

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMASET.ORG



**EMERGENCY MEDICAL SERVICES  
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM**



An Advance Request to Limit the Scope of Emergency Medical Care

I, \_\_\_\_\_, request limited emergency care as herein described.  
*(print patient's name)*

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

---

Patient/Legally Recognized Health Care Decisionmaker Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Legally Recognized Health Care Decisionmaker's Relationship to Patient \_\_\_\_\_

*By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.*

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

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Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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Print Name \_\_\_\_\_ Telephone \_\_\_\_\_

**THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY**

**PREHOSPITAL DNR REQUEST FORM**

~~The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) form.~~

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
 <p>EMSA #111 B (Effective 1/1/2016)*</p>	<p><b>Physician Orders for Life-Sustaining Treatment (POLST)</b></p> <p><i>First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</i></p>	
	Patient Last Name:	Date Form Prepared:
	Patient First Name:	Patient Date of Birth:
	Patient Middle Name:	Medical Record #: (optional)
<p><b>A</b></p> <p>Check One</p>	<p><b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>if patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i></p> <p><input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A <b>requires</b> selecting Full Treatment in Section B)</p> <p><input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow Natural Death)</p>	
	<p><b>B</b></p> <p>Check One</p>	<p><b>MEDICAL INTERVENTIONS:</b> <i>if patient is found with a pulse and/or is breathing.</i></p> <p><input type="checkbox"/> <b>Full Treatment</b> – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.</p> <p><input type="checkbox"/> <i>Trial Period of Full Treatment.</i></p> <p><input type="checkbox"/> <b>Selective Treatment</b> – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.</p> <p><input type="checkbox"/> <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i></p> <p><input type="checkbox"/> <b>Comfort-Focused Treatment</b> – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i></p> <p>Additional Orders: _____</p>
<p><b>C</b></p> <p>Check One</p>		<p><b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food by mouth if feasible and desired.</i></p> <p><input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____</p> <p><input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____</p> <p><input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____</p>
	<p><b>D</b></p>	<p><b>INFORMATION AND SIGNATURES:</b></p> <p>Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker</p> <p><input type="checkbox"/> Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive: _____</p> <p><input type="checkbox"/> Advance Directive not available Name: _____</p> <p><input type="checkbox"/> No Advance Directive Phone: _____</p> <p><b>Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)</b></p> <p>My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences</p> <p>Print Physician/NP/PA Name: _____ Physician/NP/PA Phone #: _____ Physician/PA License #, NP Cert. #: _____</p> <p>Physician/NP/PA Signature: (required) _____ Date: _____</p> <p><b>Signature of Patient or Legally Recognized Decisionmaker</b></p> <p>I am aware that this form is voluntary. By signing this form the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form</p> <p>Print Name: _____ Relationship: (write self if patient) _____</p> <p>Signature: (required) _____ Date: _____</p> <p>Mailing Address (street/city/state/zip): _____ Phone Number: _____</p>
<p><b>FOR REGISTRY USE ONLY</b></p>		
<p><b>SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED</b></p>		
<p><small>*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid</small></p>		

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
<b>Patient information</b>		
Name (last, first, middle):	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
<b>NP/PA's Supervising Physician</b>		<b>Preparer Name (if other than signing Physician/NP/PA)</b>
Name:	Name/Title:	Phone #:
<b>Additional Contact</b> <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:
<b>Directions for Health Care Provider</b>		
<b>Completing POLST</b>		
<ul style="list-style-type: none"> <li>• <b>Completing a POLST form is voluntary.</b> California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.</li> <li>• <b>POLST does not replace the Advance Directive.</b> When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.</li> <li>• POLST must be completed by a health care provider based on patient preferences and medical indications.</li> <li>• A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.</li> <li>• A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.</li> <li>• To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.</li> <li>• If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.</li> <li>• Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.</li> </ul>		
<b>Using POLST</b>		
<ul style="list-style-type: none"> <li>• Any incomplete section of POLST implies full treatment for that section.</li> </ul>		
<b>Section A:</b>		
<ul style="list-style-type: none"> <li>• If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."</li> </ul>		
<b>Section B:</b>		
<ul style="list-style-type: none"> <li>• When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).</li> <li>• Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.</li> <li>• IV antibiotics and hydration generally are not "Comfort-Focused Treatment."</li> <li>• Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."</li> <li>• Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.</li> </ul>		
<b>Reviewing POLST</b>		
It is recommended that POLST be reviewed periodically. Review is recommended when:		
<ul style="list-style-type: none"> <li>• The patient is transferred from one care setting or care level to another, or</li> <li>• There is a substantial change in the patient's health status, or</li> <li>• The patient's treatment preferences change.</li> </ul>		
<b>Modifying and Voiding POLST</b>		
<ul style="list-style-type: none"> <li>• A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.</li> <li>• A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.</li> </ul>		
This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit <a href="http://www.caPOLST.org">www.caPOLST.org</a> .		
<b>SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED</b>		

• ~~EMSA/ICEMA approved DNR medallion.~~

