Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

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

DATE: September 14, 2016

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

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

SUBJECT: **IMPLEMENTATION OF POLICIES/PROTOCOLS EFFECTIVE OCTOBER 15, 2016**

The policies/protocols listed below are effective October 15, 2016.

ICEMA Reference Number and Name

2120 - O1A & F-1612 Scantron Form Instructions (DELETE)
7010 - BLS/LALS/ALS Standard Drug & Equipment List
7020 - EMS Aircraft Standard Drug & Equipment List
7040 - Medication - Standard Orders
8010 - Interfacility Transfer Guidelines
8090 - Fort Irwin Continuation of Care
8120 - Continuation of Care (San Bernardino Only)
9010 - General Patient Care Guidelines
10190 - Procedure - Standard Orders
11050 - Tachycardias - Adult
12020 - Withholding Resuscitative Measures
14020 - Airway Obstruction - Pediatric
14040 - Cardiac Arrest - Pediatric
14060 - Seizure - Pediatric
14070 - Burns - Pediatric
15010 - Trauma - Adult (15 years of age and older)

Please insert and replace the attached policies, protocols and Table of Contents in the EMS Policy, Procedure and Protocol Manual with the updated documents and ensure every station or facility has a reference copy. The ICEMA policies and protocols can also be found on ICEMA's website at ICEMA.net under the Policy, Procedure and Protocol Manual section.

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The attached documents include changes in ICEMA's paramedic (EMT-P) optional scope of practice. Medical Advisory Committee (MAC) representatives, which include first responder and transport providers, EMS medical directors, specialty center physicians and nurses, reviewed current research, multi-year usage data, and outcome information. Following a lengthy discussion at the MAC meeting on August 25, 2016, MAC voted to recommend the removal of the following procedure and medications from the ICEMA EMT-P optional scope of practice:

- Pediatric intubation
- Procainamide
- Verapamil
- Oxytocin

The MAC review began with a request from the Emergency Medical Services Authority (EMSA) for ICEMA to update the status and renewal of all local EMT-P optional scope of practice items.

If you have any questions related to documents in the manual, please contact Ron Holk, RN, EMS Coordinator, at (909) 388-5808 or via e-mail at ron.holk@cao.sbcounty.gov.

TL/RV/jlm

Attachments

c: File Copy

POLICIES/PROTOCOLS CHANGES EFFECTIVE OCTOBER 15, 2016

Reference #	Name	Changes
NEW		
None		
1000 ACCREDITATION AND CERTIFICATION		
None		
2000 DATA COLLECTION		
3000 EDUCATION		
None		
4000 QUALITY IMPROVEMENT		
None		
5000 MISCELLANEOUS SYSTEM POLICIES		
None		
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
None		
7000 STANDARD DRUG & EQUIPMENT LISTS		
7010	BLS/LALS/ALS Standard Drug & Equipment List	• Removed Procainamide and Verapamil. • Removed Endotracheal tubes uncuffed - all sizes and ET tube holders - pediatric. • Removed Laryngeal blades - #0, #1, #2 curved and/or straight. • Removed Pitocin.
7020	EMS Aircraft Standard Drug & Equipment List	• Removed Procainamide and Verapamil. • Removed Endotracheal tubes uncuffed - all sizes and ET tube holders - pediatric. • Removed Laryngeal blades - #0, #1, #2 curved and/or straight. • Removed Endotracheal tubes, cuffed - 2.5, 3.0, 3.5, 4.0 or 4.5, 5.0 or 5.5 with stylet. • Removed Pitocin.
7040	Medication - Standard Orders	• Removed Procainamide and Verapamil. • Clarified use of the policy requiring consultation with base hospital physician for uses, dose and route other than those listed. • Added parameter/clarification for use of Fentanyl in chest pain. • Added IM/IN to Narcan for pediatric patients. • Removed Magnesium Sulfate concentration from dosing.

POLICIES/PROTOCOLS CHANGES EFFECTIVE OCTOBER 15, 2016

Reference #	Name	Changes
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		
8010	Interfacility Transfer Guidelines	• Formatting and verbiage changes for clarification. • Removed Procainamide and Pitocin for transport IV solutions.
8090	Fort Irwin Continuation of Care	• Added STEMI and Stroke Continuation of Care. • Verbiage changes to comply with government requirements.
8120	Continuation of Care	• Removed Procainamide for transport patients.
9000 GENERAL PATIENT CARE POLICIES		
9010	General Patient Care Guidelines	• Formatting and verbiage changes for clarification.
10000 SKILLS		
10190	Procedure - Standard Orders	• Removed Oral Endotracheal Intubation - Pediatric (less than 15 years of age).
11000 ADULT EMERGENCIES		
11050	Tachycardias - Adult	• Removed Procainamide and Verapamil.
12000 END OF LIFE CARE		
12020	Withholding Resuscitative Measures	• Name changed from Withholding Resuscitative Measures to End of Life Care and Decisions. • Verbiage changes and additions consistent with End of Life Options Act.
13000 ENVIRONMENTAL EMERGENCIES		
None		
14000 PEDIATRIC EMERGENCIES		
14020	Airway Obstruction - Pediatric	• Verbiage changes for clarification and consistency. • Removed references to endotracheal intubation as an ALS option.
14040	Cardiac Arrest - Pediatric	• Verbiage changes for clarification and consistency. • Removed references to endotracheal intubation as an ALS option.
14060	Seizure - Pediatric	• Verbiage changes for clarification and consistency.
14070	Burns - Pediatric	• Verbiage changes for clarification and consistency. • Removed references to endotracheal intubation as an ALS option.
15000 TRAUMA		
15010	Trauma - Adult	• Clarified use of long backboard.

POLICIES/PROTOCOLS CHANGES EFFECTIVE OCTOBER 15, 2016

DELETIONS		
2120	01A & F-1612 Scantron Form Instructions	• Scantron no longer used in the ICEMA region.
Below are some of the policies/protocols designated for review in the next few months. If there are specific policies/protocols recommended for review, please contact ICEMA.		
None		

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SERIES	SYSTEM POLICIES AND PROCEDURES	EFFECTIVE DATE
1000	**CERTIFICATION, ACCREDITATION and AUTHORIZATION**	
1020	EMR Certification	07/01/15
1030	EMT Certification	07/01/15
1040	EMT-P Accreditation	09/01/15
1050	MICN Authorization - Base Hospital, Administrative, Flight Nurse, Critical Care Transport	04/01/16
1060	Certification/Accreditation Review Policy	12/01/14
1070	EMT/AEMT Incident Investigation, Determination of Action, Notification, and Administrative Hearing Process	08/15/14
1090	Criminal History Background Checks (Live Scan)	08/15/14
1100	AEMT Certification	07/01/15
1110	RCP Authorization	04/01/16
1120	EMT-P Student Field Internship Requirements	04/15/16
2000	**DATA COLLECTION**	
2010	Requirements for Patient Care Records	05/01/06
2020	ICEMA Abbreviation List	03/15/12
2030	Minimum Documentation Requirements for Transfer of Patient Care	03/15/12
~~**2120**~~	~~**Instructions for the 01A/F1612 Forms**~~ **DELETE**	**10/15/16**
3000	**EDUCATION**	
3020	Continuing Education Provider Requirements	07/01/15
3030	EMT Continuing Education Requirements	03/15/11
4000	**QUALITY IMPROVEMENT**	
4010	Continuous Quality Improvement Plan	02/28/11
5000	**MISCELLANEOUS SYSTEM POLICIES**	
5010	Licensure Changes 911 Receiving Hospitals	01/01/10
5020	Base Hospital Selection Criteria	07/15/00
5030	Review of Policies and Protocols	02/01/16
5040	Radio Communication Policy	02/01/16
5050	Medical Response to a Multi-Casualty Incident	04/01/13
5050 I/Mono Annex	Inyo and Mono Counties Medical Response to a Multi-Casualty Incident	05/01/11
5060	MCI Definitions/Key ICS Positions	01/01/10
5070	Medical Response to Hazardous Materials/Terrorism Incident	04/01/13
5080	ICEMA Ground Based Ambulance Rate Setting Policy-San Bernardino County	05/08/12
6000	**SPECIALTY PROGRAM/ PROVIDER POLICIES**	
6010	Paramedic Vaccination Policy	04/01/13
6030	AED Service Provider Policy - Public Safety	07/01/15
6040	AED Service Provider - Lay Rescuer	07/01/15
6060	Specialty and Optional Scope Program Approval Policy	07/01/15
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Designation Policy	02/01/16

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6000	**SPECIALTY PROGRAM/ PROVIDER POLICIES (CONTINUED)**	
6080	Paramedic Blood Draw for Chemical Test at the Request of a Peace Officer	04/01/13
6090	Fireline Paramedic	02/01/16
6100	Neurovascular Stroke Receiving Centers Designation Policy *(San Bernardino County Only)*	02/01/16
6110	Tactical Medicine Program	07/01/15
6120	Emergency Medical Dispatch Center Requirements (*San Bernardino County Only)*	08/15/13
6130	Medical Priority Dispatch Minimum Response Assignments for Emergency Medical Dispatch (EMD) Categories	08/15/13
6140	Smoke Inhalation/CO Exposure/Suspected Cyanide Toxicity	06/01/14
6150	Trial Study Participation	03/01/15
7000	**STANDARD DRUG & EQUIPMENT LISTS**	
7010	BLS/LALS/ALS Standard Drug and Equipment List **REVISED**	**10/15/16**
7020	EMS Aircraft Standard Drug and Equipment List **REVISED**	**10/15/16**
7030	Controlled Substance Policy	06/01/15
7040	Medication - Standard Orders **REVISED**	**10/15/16**
8000	**TRANSPORT/TRANSFERS AND DESTINATION POLICIES**	
8010	Interfacility Transfer Guidelines **REVISED**	**10/15/16**
8020	Specialty Care Transport	04/01/16
8050	Transport of Patients (BLS)	02/01/92
8060	Requests for Hospital Diversion Policy *(San Bernardino County Only)*	04/01/13
8070	Aircraft Rotation Policy *(San Bernardino County Only)*	04/01/13
8090	Fort Irwin Continuation of Care **REVISED**	**10/15/16**
8110	EMS Aircraft Permit Policy	10/01/13
8120	Continuation of Care *(San Bernardino County Only)* **REVISED**	**10/15/16**
8130	Destination Policy	02/01/16
8140	Transport Policy *(Inyo County Only)*	12/15/15
	PATIENT CARE POLICIES	
9000	**GENERAL PATIENT CARE POLICIES**	
9010	General Patient Care Guidelines **REVISED**	**10/15/16**
9020	Physician on Scene	04/01/13
9030	Responsibility for Patient Management Policy	04/01/13
9040	Reporting Incidents of Suspected Abuse Policy	04/01/13
9050	Organ Donor Information	04/01/13
9060	Local Medical Emergency Policy	02/01/14
9070	Applying Patient Restraints Guidelines	05/01/06
9080	Care of Minors in the Field	02/01/16
9090	Patient Refusal of Care - Adult	06/01/14
9110	Treatment of Patients with Airborne Infections and Transport Recommendations	09/15/11
9120	Nausea and Vomiting	12/01/14

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10000	**SKILLS**	
10190	Procedure - Standard Orders **REVISED**	**10/15/16**
11000	**ADULT EMERGENCIES (15 YEARS OF AGE AND OLDER)**	
11010	Respiratory Emergencies - Adult	07/01/15
11020	Airway Obstruction - Adult	08/15/14
11040	Bradycardias - Adult	08/15/14
11050	Tachycardias - Adult **REVISED**	**10/15/16**
11060	Suspected Acute Myocardial Infarction (AMI)	06/01/15
11070	Cardiac Arrest - Adult	02/01/16
11080	Altered Level of Consciousness/Seizures - Adult	08/15/14
11090	Shock (Non-Traumatic)	08/15/14
11100	Burns - Adult	07/01/15
11110	Stroke Treatment - Adult	02/01/16
12000	**END OF LIFE CARE**	
12010	Determination Of Death on Scene	08/15/14
	Coroners Worksheet of Death - EMS Report of Death Form	09/15/12
12020	End of Life Care and Decisions **REVISED**	**10/15/16**
13000	**ENVIRONMENTAL EMERGENCIES**	
13010	Poisonings	08/15/14
13020	Heat Related Emergencies	08/15/14
13030	Cold Related Emergencies	06/01/15
14000	**PEDIATRIC EMERGENCIES (LESS THAN 15 YEARS OF AGE)**	
14010	Respiratory Emergencies - Pediatric	07/01/15
14020	Airway Obstruction - Pediatric **REVISED**	**10/15/16**
14030	Allergic Reactions - Pediatric	08/15/14
14040	Cardiac Arrest - Pediatric **REVISED**	**10/15/16**
14050	Altered Level of Consciousness - Pediatric	08/15/14
14060	Seizure - Pediatric **REVISED**	**10/15/16**
14070	Burns - Pediatric **REVISED**	**10/15/16**
14080	Obstetrical Emergencies	08/15/14
14090	Newborn Care	08/15/14
15000	**TRAUMA**	
15010	Trauma - Adult (15 years of age and older) **REVISED**	**10/15/16**
15020	Trauma - Pediatric (Less than 15 years of age)	06/01/15
15030	Trauma Triage Criteria	02/01/16
15040	Glasgow Coma Scale Operational Definitions	04/01/13
15050	Hospital Emergency Response Team (HERT) Policy	10/15/13

01A & F-1612 SCANTRON FORM INSTRUCTIONS

DELETE

PURPOSE

To help field providers in the proper, complete, and accurate documentation of prehospital care using ICEMA Run Report Forms. The 01A Narrative Form serves as the regional version of the EMT-P's Patient Care Record (PCR) as required in Title 22, Division 9 of the California Administrative Code (EMT-P regulations). The computer readable F-1612 data form is a data collection instrument designed to provide all core data for quality assurance, statewide and regional EMS system evaluation. Questions regarding completion of these forms, or to arrange a class teaching the use of these forms, contact ICEMA at 909-388-5820.

MARKING THE FORM

The 01A Form is a 4-part form printed on carbon less, pressure sensitive (NCR) paper. EMS personnel completing the form must make marks with a standard ink pen heavily enough to leave a legible impression on all copies. We recommend placing the form on a clipboard or other hard surface while you are making marks. When completing the reverse sides of the form, write on each form separately as the NCR paper will cause marks on the front of the O1A form.

DISPOSITION OF COPIES

WHITE:

The EMS service provider agency will keep the ***white*** (original/first part) copy of the 01A form.

GREEN:

The ***green*** copy of the 01A form becomes part of the patients' medical record for the receiving hospital. It is to accompany the patient to the receiving hospital for inclusion in the patient's medical record. When a transporting service provider (ambulance) arrives and prepares to transport, the first service provider agency will give their green medical copy to the transporting agency, even if the 01A form has not been completed. The 01A form may then be completed after the patient has left the scene, noting that fact in the comments. Do NOT have the patient wait for transporting while you are completing a form.

YELLOW:

The EMS service provider agency will send ***all designated yellow*** copies of the 01A form to ICEMA each month. ***Designated copies*** **are 1) patients under 18 years of age, 2) expanded scope skills, 3) expanded scope medications, and 4) ET attempts**. ICEMA

reserves the discretion to request additional 01A forms from each agency. The Agency EMS Coordinator, and/or the assigned Base Hospital PLN must review each 01A with expanded scope skills and/or medications before sending them to ICEMA.

PINK:

The ***pink*** copy of the 01A form serves as a billing or extra copy for the EMS service provider agency (the field provider's employer). This copy may be used for educational purposes or prehospital research that is being conducted. It may be sent to the base hospital or other requesting party as requested. When using this copy for outside agencies, black out the patient's name and any personal identifying information.

WHEN TO COMPLETE A FORM

For every patient contact, a 01A form is required, including interfacility transfers. Each patient on scene will have a separate form completed. Each ALS provider, who makes patient contact, must complete a 01A form for that patient. Separate crews from the same provider that give care to the same patient, must complete a separate 01A form for the care they gave. Record items that reflect only those services provided by the person(s) completing the form. When one provider takes over care from another, record the ICEMA number from the 01A form completed by the transferring care provider in the space titled "Other ICEMA #."

EMERGENCY CALLS

EMT-P'S must completely fill out a 01A form for every emergency call where patient contact is made.

Exceptions are as follows:

1. Weight may be left blank if not used for treatment;
2. Mechanisms of injury should be blank for non trauma patients;
3. Zones may be blank if not applicable to the local area;
4. EKG rhythm should be blank if no EKG is done.

INTERFACILITY TRANSFERS

For reporting purposes, an "interfacility transfer" is a call on which a patient is transported from a hospital to another health care facility or other location. This includes calls on which they took a patient from a hospital to a nursing home (or vice versa); from a hospital to the patient's home; or from a hospital to another hospital. **ALS interfacility transfers (paramedic on the unit) require both a 01A Narrative form and an F-1612 data form.**

The following 01A Form items are to be completed for all ALS interfacility transfers:

DELETE

1. patient name, home address and zip code
2. patient age and sex
3. chief complaint
4. blood pressure, respiration rates, respiratory efforts, capillary refill, eye opening
5. verbal response, motor response
6. head-to-toe physical assessment
7. care rendered (if any), response to treatment rendered and time administered
8. incident number
9. run dates
10. unit number
11. location (address of facility where patient is picked up)
12. times call for transport received
13. time dispatched (en route)
14. time of arrival at transferring hospitals
15. time departed a transferring hospital
16. time arrived at destination facility
17. receiving hospitals (or facility) code (for location to which patient transferred)
18. attendant signatures(s)
19. signature of person receiving the patient at the destination facility

CANCELED CALLS

A call is considered "canceled en route" when the dispatcher notifies the unit that they have canceled before the unit arrives on scene; that is, **before they make patient contact**. A **01A FORM IS NOT REQUIRED for a call that is canceled enroute**. We recommend that provider agencies use a form for data collection (for example, a dispatch report form) that contains, at a minimum, the following information:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. call outcomes ("canceled en route")
8. attendant certification number(s)
9. provider

DRY RUNS

For reporting purposes, a "dry run" is a call on which **no patient contact is made at the scene. A 01A FORM IS NOT REQUIRED FOR THIS TYPE OF RUN.** However, if patient contact is made, and the patient refuses treatment or transport, an O1A form is

DELETE

required. For dry runs with no patient contact, provider agencies may use an alternative method of data collection of their choice that contains, at a minimum, the following data:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. Call outcomes ("dry run-no pt.")
8. attendant certification number(s)
9. provider and unit number

DETAILS FOR COMPLETING THE PCR 01A NARRATIVE FORM

CANCELED ~ AMA ~ TRANSPORT ~ AIR

Mark the appropriate box for the run.

ICEMA NUMBER

The preprinted ICEMA number is located at the upper left corner of the 01A Narrative form. Mark this number on the corresponding F-1612 data form in the spaces provided for "ICEMA #" (central bottom portions of the data form).

PRIM. INC.

Obtain this number from the dispatcher, normally after completion of the call. This is the incident (dispatch) number of the provider agency that sends the unit to the scene. Write the number in the space shown.

OTHER PROVIDER

Document the transporting agency's abbreviated name and the unit number of the vehicle when you transfer patient care to another provider for transport.

DATE

Write the date on which the provider agency received the call. Use a six-digit number. For example, enter 06/01/02 for June 1, 2002.

UNIT

DELETE

This space is for the unit number (as assigned by the provider agency) of the vehicle that responded to the incident.

LOCATION OF CALL

Write the location of the incident as supplied by the agency dispatcher. Record the street number and street name when available. If they do not provide these items, record the cross streets and nearest city or community. Do not write "home" or "same."

CITY

Write the name of the city where the incident occurred. Use this to decide the city code entered on the F-1612 data form.

ZONE

Use this space to record the State Fire Marshall's fire demand zone number or the zone within a city designated by an EMS provider agency. ICEMA does not require the zone, use at the discretion of the provider agency.

NAME ~ ADDRESS ~ CITY ~ STATE ~ ZIP

Write in the patient's full name (first name, middle initial if any, and last name) on the line provided near the top of the form. Write the patient's street address, mailing address if different, the city where the patient resides, two-letter postal abbreviations for the state, and zip code on the second blank line. While on scene, and the patient is in a life-threatening situation or unable to provide an address, obtain the information from hospital personnel at the receiving hospital.

PHONE

Record telephone number to include area code.

SOCIAL SECURITY NUMBER

Enter nine-digit number.

AGE

After identifying the patient at the scene and inquiring about his or her age, record the age in years in the space shown.

DOB

DELETE

Record the patient's date of birth in 6-digit format, for example, 01/01/02.

M/F

Record the patient's sex. Check the box before "M" for male, or "F" for female.

APPROX. WEIGHT

For all pediatric patients, write the patient's weight, in kilograms, in the space provided. For adults, record the weight only if necessary to treatment (for example, if drug dosage for patient condition depends upon body weight).

APPROX. HEIGHT

For all pediatric patients, record the patient's height, in feet and inches, in the space provided. For adults, record height only if weight is also necessary.

PT __ OF __

Enter assigned patient number out of total number of patients transported.

CARE PRIOR TO ARRIVAL

Check the appropriate box for the type of emergency care given prior to your unit's arrival.

1. None: No prior care.
2. CPR: If started prior to your arrival on scene
3. Other BLS: Any procedure listed in the Care Rendered-left column on the F-1612 data form.
4. ALS: Any procedure listed in the Care Rendered-right column on the F-1612 data form.

PRIOR CARE GIVER

Mark the appropriate box to show the type of agency/individual providing care prior to your unit's arrival on the scene.

1. CITZ.: a citizen, bystander, or relative provided care.
2. None: no prior caregiver.
3. Medical: physician, nurse, first responders, ski patrol, or other trained medical person on a scene provided prior care.
4. FD/BLS: a BLS unit provided prior care.
5. Law Enforce: police, sheriff, or other law enforcement personnel provided care.

DELETE

6. FD/ALS: a non-transporting ALS unit provided prior care.
7. ALS Amb: ALS ambulance personnel provided prior care.

RECEIVED

Time call is first received by EMS Provider Agency. This time may be received from the dispatcher after completion of the call. Write the time, in hours and minutes, using military time (a 24-hour clock) in the box provided. Valid times range from zero (midnight) to 2359 (11:59 p.m.). **Do NOT use 2400. Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

EN ROUTE

Time that the response unit begins physical motion; i.e. wheels begin to turn.

ARRIVE

Time the EMS unit stops physical motion at scene on staging area; i.e. wheels stop turning. (Last place that the unit vehicle stops prior to assessing the patient.)

PT. CONTACT

Time response personnel establish direct contact with patient.

DEPART

Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARRIV. DEST/END CALL

Time when patient arrives at destination or transfer point, i.e. wheels stop turning. Leave blank if your unit is not transporting the patient. Note**: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.**

AVAILABLE

Record the time that the unit is back in service and available for another call, whether they transported the patient or not.

DELETE

DELETE

CODE EN ROUTE

Circle the number that corresponds to the definitions below by which the unit responded to the incident:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

CODE DEPART

Circle the number that corresponds to the mode of transportation the ambulance utilized enroute to the hospital (1, 2, or 3, as described above). If transportation does not occur, leave this item blank.

ODOMETER

Use this section as directed by your employer. ICEMA does not require odometer readings.

FAC. CONTACTED

Write an abbreviation for the base hospital contacted on this call. If the unit never attempted to make voice contact with the Base Hospital, write "none." If the Base Hospital was successfully contacted, mark the type of instrument/frequency utilized:

1. BH: Base Hospital
2. VHF: EMS/HEAR radio
3. UHF: Bio-com
4. Phone: Land line telephones
5. CELL: Cell phone
6. 800Mhz: San Bernardino County system
7. None: In Radio Communication failure record the BH name

CONTACT TIME

Record the time contact was initiated with the base hospital.

RECEIVING HOSPITAL

Record the name or appropriate abbreviation for the hospital where the patient was transported.

Mark the ONE category that best describes the reason for selection of the receiving hospital:

Pt. Request: patient or patient's physician requested this facility
Diversion: the original receiving hospital selected was on diversion for this type of call
Trauma: transported to this facility because they require a trauma center
RCF: radio communication failure
Peds trauma: they require a pediatric trauma center
Reroute: the receiving hospital destination changed while the unit was en route from scene. E.g., a change in patient condition required selection of a different facility). Not to include change in the destination based upon hospital status (see "diversion")
Closest: the hospital is selected because it is closest to the scene
Other: a reason other than those listed above in selecting the receiving hospital

CHIEF COMPLAINT

Use the blank space under this heading to describe details of the patient's problem. Describe the location of injury; (head, face, neck, chest, abdomen, rt. or lt. arm or leg, rt. or lt. hand or foot), or sites of pain; the type of injury or pain (e.g., fracture, laceration, etc.), and other medically relevant signs and symptoms (e.g., estimated blood loss). Include drug or alcohol use here.

MECHANISM OF INJURY

For all trauma patients, record the reported cause of injury. Categories include motor vehicle accidents (MVA), motorcycle collisions (MCA), GSW, stabbing etc. For falls, specify if more than 20 feet. Show whether injury is blunt or penetrating. If undeterminable, write "unknown." Circle “Y”-yes or “N”-no to the following questions; did the patient wear a helmet, a seat belt, have a loss of consciousness (LOC), and was an airbag inflated?

MED. HISTORY

Use this space to record the patient’s medical history. History may include cardiac, respiratory, liver, kidney, or other known disease, any recent and/or related illnesses, medical conditions, hospitalizations, history of trauma, or medical treatments. Also, record the time of injury or time of onset of symptoms as stated by the patient. Check appropriate predesignated diagnosis if one applies to the patient.

MEDICATION

Write the names of all prescription or over-the-counter medications the patient is currently taking. Abbreviate as necessary. If they do not know the specific name of the drug, record the class of drug or the action it takes (e.g., insulin, diuretic, an antidepressant,

DELETE

antihistamine, etc.). Include dose and frequency if it is taken daily (e.g., Bid, T.i.d., QD). Bring any medication not quickly identifiable to the hospital with the patient.

ALLERGIES

Mark the box 'NKA' for no known allergies. Otherwise, record the names of any medications to which the patient has had an allergic reaction. Also record any other allergies either related to the current problem (for example, the mechanism of injury is "bite/sting" and the patient is allergic to bee stings), or environmental allergies (for example Latex allergies).

BLOOD PRESSURE

Record the time (use a 24-hour clock) and initial blood pressure reading as systolic/diastolic. Note if auscultation or palpation was used to obtain B/P. Record blood pressure readings as required by protocol. If you require additional space, use the Narrative section.

PULSE

Record the rate and quality of the pulse (e.g., thready, bounding, irregular). Use appropriate abbreviations (e.g., 70 norm., 60 irreg.). Record repeated pulse rate and quality as required by protocol. Use the Narrative section for additional space, if required.

RESPIRATION

Record the rate, number of respiration's per minute/quality of respiration's (e.g., clear, wheezes, rales, unequal, or absent). Record repeated respiratory rate and quality as required by protocol. Describe lung sounds as auscultated with a stethoscope. Use the Narrative section for additional space, if required.

PULSE OX

Give numeric value as a percentile and whether it was taken on room air or with supplemental oxygen.

SKIN COLOR

Mark the category that most closely matches the patient's skin color upon initial assessment: normal, pale/ashen, cyanotic, or flushed. Check box "A" for first time observed and box "B" where a vital sign is repeated record time for "A" and time "B" in line provided.

DELETE

DELETE

MOISTURE

Mark how much skin moisture noted on initial assessment: normal, dry, moist, or profusely diaphoretic.

SKIN TEMP

Mark the patient's skin temperature as noted on initial assessment: hot, warm, cool, or cold.

PUPILS - LT (LEFT) RT (RIGHT)

Mark the boxes that best describes the pupillary response or status upon initial assessment of the patient. Separate columns are provided for description of pupillary response in left and right eyes.

RESPIRATORY EFF.

Record the patient's visible respiratory effort (chest wall movement), mark the box next to the category that better describes the present condition for this patient--normal, or abnormal (shallow/retractive/none).

1. Normal: easy, unlabored, deep respirations.
2. Shallow: diminished volume of respirations.
3. Retractive: this involves the use of the accessory and/or abdominal muscles for breathing.
4. None: mark if patient has no apparent respirations.

If no box is marked, it will be assumed that no assessment was done.

CAPILLARY REFILL

Mark the box next to the category that best describes the patient's capillary refill upon assessment.

1. Immediate: return of color in two seconds or less.
2. Delayed: color does not return in less than two seconds
3. None: no return of color.

EYE OPENING

Note the patient's initial ability to open his/her eye(s). Mark the box next to the appropriate category.

1. Spontaneous: patients' eyes open without stimulation; patient can close eyes upon

request.
2. To voice: eyes open when the patient's name is spoken or shouted.
3. To pain: eyes open in response to a standard pain stimulus.
4. None: eyes do not open despite a stimulus.

VERBAL RESPONSE

Mark the box next to the category that describes this patient's initial best verbal response.

1. Oriented: correctly responds when asked name, place, date, and history of an event.
2. Confused: incorrectly responds to questions, but can produce phrases of more than two
3. Inappropriate: able to produce only an intact word or two in response to physical stimulation.
4. Incomprehensible: able to produce sounds (mumbling or groaning), but no words.
5. None: no verbal response to any stimulation.

MOTOR RESPONSE

Mark the box next to the patient's initial best motor response.

1. Obedient: Pt. ability to comprehend, physically execute a spoken or written instruction.
2. Purposeful: patient responds to a standard pain stimulus.
3. Withdrawal: no verbal response; the elbows flex rapidly with no muscle stiffness.
4. Flexion: no verbal response; the elbows flex slowly and muscle is stiff.
5. Extension: no verbal response; arms and/or legs out; muscles are stiff.
6. None: no verbal or motor response.

PULSE

Mark the box next to the appropriate area (Femoral, Radial, Carotid) as present or absent.

GCS

Enter the GCS (Glasgow Coma Scale) and include in report to base hospital.

PT PHYSICIAN

Enter name of patients' physicians, if known.

TEMP

Enter patients' body temperature and location taken (oral, tympanic).

DELETE

DELETE

BLOOD GLUCOSE D50/D25

Enter blood glucose numeric value before D50/D25 was given and enter a secondary numeric value for the repeat blood glucose after the administration of D50/D25.

END-TIDAL Co2 DETECTED

If the patient is intubated, note detection of Co2 after placement, before the patient is moved and after moving patient.

SECONDARY SURVEY

Mark the box for the appropriate category in each section of the "**neuro/head**" survey.

WNL: within normal limits.
N/A: not applicable.
ABN: abnormal.

In the comments section next to "**neck**", mark box if no JVD (jugular venous distention); next to "**chest**", mark if negative barrel hoop; next to "**abdomen**", mark if soft and/supple; next to "**back-spine**", mark if full spinal immobilization was instituted (this constitutes rigid collar, head/chin straps, head bed, long board and straps); next to "**pelvis**", mark box if negative or no instability noticed; next to "**extreme**", mark box if no distal edema and if the patient has full range of motion.

NARCOTIC GIVEN ~ NARCOTIC WASTED

Enter the amount of the narcotic given to patient. Enter the amount, date, time, and location where narcotic was wasted. The EMT-P and the Nurse who witnessed the waste of the narcotic must sign in the appropriate area.

EKG - DEFIB RHYTHM

When an EMS field provider places a patient on the monitor, this area must be completed. Do not record a rhythm obtained by another unit. Record the initial and any subsequent rhythms in the spaces provided. Enter energy level in joules if patient is cardioverted or defibrillated, and rhythm following procedure. If TCP is utilized note capture, rate and amperes used. If additional space is needed, continue in the Narrative/Assessment section.

CARE RENDERED

Record the time that any medication or procedure was ordered or initiated by the EMT/Paramedic, using the 24-hour clock format. Identify medications and procedures

prior to Base Hospital contact with the abbreviation "PTC" immediately following the time. **Be sure to include all types of treatment in this section. Record only those treatments provided by attendants signing this form.** Record the time when each procedure was initiated. Include RT/Size-route and size of appliance used, dose and response to treatment in sections provided. Record the complete name of all drugs administered, with the time ordered, route, dose, and time administered. Use abbreviations as necessary. If the Base Hospital ordered, medications or procedures but where not completed please note that fact in this section

PQRST

Record in the PQRST box as applicable.

"P" Provoke-what provoked pain?
"Q" Quality of pain-sharp/dull?
"R" Radiate-where does the pain radiate?
"S" Severity-have the patient rate on a 1-10 scale how severe they feel the pain is, one being the least pain they've experienced and 10 being the worst.
"T" Time-how long have they had the pain?

NARRATIVE/ASSESSMENT

Use this section for details concerning the patient. Include exceptions and unusual conditions or circumstances. Record the type of care administered prior to arrival of this unit. Overall change (or no change) in patient condition. Do not record personal opinions. Note pertinent negatives in physical assessment and response or change after care rendered. Use **ICEMA Supplemental Patient Report** form if more space is needed.

3 TEAM MEMBER SIGNATURE AREAS

This area is for the name and Accreditation/Certification number of the team members. Mark the appropriate box for each team member.

1. Patient Attendant: The team member responsible for patient care.
2. Radio Attendant: The team member who made contact with the Base Hospital.
3. Completed form: The team member who actually completed the O1A form.
4. Other: Mark this box if there is a third member (trainee or ride out).

FORM NOT COMPLETED ON SCENE

Mark this box when the O1A form is not completed on scene.

DELETE

PT RECEIVED BY

The physician or nurse taking responsibility for the patient must sign this area upon arrival at the receiving hospital or facility. When an air ambulance takes a patient from a ground ambulance for further transport, the person on the air transport crew will sign here. They now assume responsibility for patient care. The ground ambulance gives the second green copy of the form to the person whose signature appears in this area.

REVERSE SIDES OF FORM

The reverse sides of the original and three copies of the 01A Narrative form contain additional printed information. When filling out the reverse sides remember to write only on the form you are using.

BACK OF FIRST (WHITE) COPY

BILLING INFORMATION

This is the provider's copy. Complete this section as directed by your employer. ICEMA does not require completion of billing information.

MEDICAL/LIABILITY RELEASE FORM

If the patient refuses treatment, have the patient complete the "Medical Liability Release Form" on the back of the first copy (white) of the 01A Narrative form. If the patient is a minor, also have the parent or guardians sign the release. Sign the release in the area for Witness 1, and obtain the signature of a second witness. If Base Hospital contact was made, mark the box next to "Yes" on the bottom of the release; otherwise, mark "No". Document in the Narrative all pertinent information regarding the incident.

PHYSICIAN'S RESPONSIBILITY

If a physician on scene states a desire to take charge of the patient, he or she must show a current California Medical Physician's License. The doctor must read the "Physician's Responsibility" statement on the back of the first copy (white) of the 01A form and must sign the form, including his or her license number and expiration date. Make Base Hospital contact and state that a physician is on scene requesting to take medical control of the patient. **If the Base Hospital physician agrees to relinquish control** you may perform any procedure or give any medication approved for use in the ICEMA region under the direction of the physician on scene. This physician must accompany the patient to the receiving facility in the ambulance. The field provider must complete the 01A form as usual.

DELETE

BACK OF SECOND (GREEN) COPY

THROMBOLYTIC ASSESSMENT

This checklist should be completed while enroute on all chest pain patients. This information should be conveyed to the Base Hospital as soon as possible.

BASE HOSPITAL/RECEIVING FACILITY

These codes are to be used to identify the Base Hospital/Receiving Facility

RULE OF NINES CHART

This chart is included to assist the provider in determining burn percentages for the adult and pediatric patient.

APGAR SCORING

This chart is available for use in assessment of the newborn infant.

STANDARDIZED ABBREVIATIONS

These should be used consistently throughout the completion of the form. If an abbreviation is questionable, completely spell out the word so it is clear and concise to any individual reading the form.

BACK OF THIRD (YELLOW) COPY

This completed form must be given to the Base Hospital PLN; if patient is transported there, OR given to your QI/EMS Coordinator if patient transported to another facility. Complete for evaluation of the advanced skills: Adult Endotracheal Intubation, Pediatric Endotracheal Intubation, Nasotracheal Intubation, Percutaneous Needle Cricothyrotomy, Intraosseous Infusion and Transcutaneous Cardiac Pacing.

1. In space provided **record the patient's name** as written on the original 01A form.
2. Record the ICEMA run report number in space provided from the front of the 01A form.
3. Check all the procedures utilized in the boxes provided.

INTUBATION

Check the box provided for an adult or pediatric patient. Then mark the route used, (nasal or oral). Enter size of ET tube, number of attempts made and yes or no to if the procedure was successful.

DELETE

DELETE

NEEDLE CRICOTHYROTOMY

Enter the size of the needle, or name of the approved device, number of attempts and if the procedure was successful.

INTRAOSSEOUS INFUSION

State the size of the IO catheter, number of attempts and if the procedure was successful.

PLACEMENT VERIFIED

Document how you verified proper placement of device/procedure.

TRANSCUTANEOUS CARDIAC PACING

Document if the transcutaneous pacer captured the rhythm:

1. HR: The rate at which the pacemaker captured.
2. AMP: The amplitude needed to capture.
3. Palpable pulse rate: The palpated HR in beats per minute.
4. B/P: Blood pressure after pacing achieved.
5. Atropine given: Yes or No.

PULSE OXIMETRY

Record numeric value in a percentage of O2 present before treatment and after treatment.

END TIDAL CO2

Record if detected-yes or no, and percentage detected.

IF THE PROCEDURE YOU USED WAS SUCCESSFUL

Explain in the narrative the patient's response to treatment.

IF THE PROCEDURE YOU USED WAS UNSUCCESSFUL

Explain in the narrative what you felt inhibited the procedure from being successful (e.g., irreg. Anatomical structure, broken equipment, incorrect placement, etc.).

FIELD ASSESSMENT/TREATMENT INDICATORS

Document all the patient indicators for the procedure performed.

DELETE

PROCEDURE PERFORMED

Document how procedure was performed: prior to contact, in radio communication failure (RCF), or upon base hospital order.

OTHER DOCUMENTATION

Document the name of the Receiving Facility, and/or the Base Hospital. Have receiving hospital physician sign the form in the space provided. The paramedic who completed the skill and the evaluation form signs the form in the space provided. The paramedic must give this form to the PLN at the contacted Base Hospital for review if the patient was transported to that facility or to their QI/EMS Coordinator if patient was transported to another facility.

PLN DOCUMENTATION

This area needs to be completed by either the PLN or QI/EMS Coordinator and sent to the ICEMA ALS Coordinator with a photocopy of both sides of the 01A form on a monthly basis.

BACK OF FOURTH (PINK) COPY

MULTIPLE PATIENT TRIAGE FORM

This area is provided to assist with multiple casualty incidents. This form is to help the team members with rapid patient assessment and organization. **Each patient requires a separate 01A Form and F-1612 data form.**

PATIENT TRANSPORTATION RECORD/MCI WORK SHEET

This is a work sheet provided to assist the paramedic with keeping track of where multiple patients are transported during a MCI. For each patient, enter:

1. name of the transporting agency
2. patient's triage tag number
3. approximate age and sex (M or F)
4. patient's triage priority status; "**I**" for immediate, "**D**" for delayed, or "**M**" for minor

Enter a brief description for chief complaint, and ETA in minutes from scene departure to arrival at receiving hospital. Record "Off Scene Time" as the time the transporting unit leaves the scene**. Following initial triage, complete a full set of Run Report Forms for each patient**. Information recorded on the multiple patient triage form can transfer to the front of the individual patient's 01A form.

INSTRUCTIONS FOR COMPLETING THE PCR F-1612 DATA COLLECTION FORM

MARKING THE FORM

The F-1612 data form is to be completed separately from the 01A form. Complete all marks on this form within the boxes or "bubbles" in ink, (any dark color except red) or a black pencil. Mark only designated boxes. No other marks or comment should appear. For optimal scanning, **do not fold, staple, paper clip, or bend this form.** The scanner will read any other writing, lines, or comments as data, even if intended as a line or comment. 'MONO Correction Tape', by TOMBOW, may be used to make corrections instantly cleanly completely and remark the error directly on film. This product is a timesaving option. White out correction fluid may also be used to correct marks made in error. Apply a thin coat; thick fluid jams the form in the scanner. In addition, use care not to white out any of the black marks along the left side of the form. Do not make any marks or let white out run in the lower left corner of the form (below "Outcome" and "Why Selected").

DISPOSITION OF FORM

Field providers will send completed F-1612 data forms to ICEMA for data processing and quality assurance review 30 days following the run date. Agencies using electronic data submission will also send their data 30 days following the run date.

WHEN TO COMPLETE A FORM

For every patient contact, including interfacility transfers, an F-1612 data form is required. If more than one patient is at the scene, a separate form must be completed for each patient. If two providers are dispatched to the same scene, each ALS provider who makes patient contact must complete an F-1612 data form. **Items recorded on the forms should reflect only those services provided by the person(s) completing the form.** For example, when one ALS unit arrives first on the scene, the paramedic would record all care rendered to the patient on their F-1612 data form. If another ALS provider takes over care, the second paramedic would record treatment performed by its personnel on a separate F-1612 data form and will write the ICEMA number of the form completed by the first ALS provider in the space for "Other ICEMA #."

EMERGENCY CALLS

For every emergency call where patient contact is made, all sections must be completed on the F-1612 data form. **Exceptions are as follows:**

1. Mechanisms of injury should be blank for non-trauma patients.

DELETE

2. EKG rhythm should be blank if no EKG is done.
3. Medications administered should be left blank if no medications where given.

INTERFACILITY TRANSFERS

In addition to the 01A narrative form, the F-1612 data form must be completed for all ALS interfacility transfers. If a hospital request a BLS transfer but they send a paramedic on the run (with or without an EMT-I), an F-1612 data form is required. If the provider makes a BLS transfer with a nurse but no paramedic, we require only the 01A form.

ALS interfacility transfers (paramedic on the unit) require both an F-1612 data form and a 01A Narrative form. The following F-1612 data form items are to be marked for ALS interfacility transfers:

1. patient sex, age, and zip code
2. number of patients
3. incident number
4. rundate (date transported)
5. city code (for the city where the transferring facility is located)
6. run code to the scene
7. category (marked "transfer")
8. receiving hospital code
9. times call for transport received
10. time enroute
11. time of arrival at transferring hospitals
12. time departed a transferring hospital
13. time arrived at destination facility
14. systolic BP, respiratory rate and effort, capillary refill, eye opening
15. verbal response, motor response
16. care rendered (ALS or BLS if any during transport)
17. response to treatment rendered and time administered
18. medications (Note: Medications that are being monitored, i.e. Magnesium Sulfate drips)
19. patient condition (change/no change enroute)
20. outcome
21. attendant accreditation/certification numbers
22. provider and unit codes

CANCELED CALLS

A call is considered “canceled enroute” when the dispatcher notifies the unit that they have canceled the call before the unit arrives on a scene or before patient contact is made.

DELETE

The following F-1612 data form items are to be marked for calls canceled enroute:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes ("canceled enroute")
8. attendant accreditation/certification number(s)
9. provider and unit numbers

DRY RUNS

For data collection a “dry run” is a call on which **no patient contact is made at the scene**. Although the 01A form is not required for this type of run, an F-1612 data form is required. If patient contact is made at the scene and refuses treatment or transport, the F1612 data form is still required.

The following F-1612 data form items are to be marked for dry runs:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes (“dry run-no pt.”)
8. Attendant accreditation/certification number(s)
9. Provider and unit numbers

DETAILS FOR COMPLETING THE F-1612 PCR DATA COLLECTION FORM

The F-1612 data form should be completed as soon as possible after the call, while the details of the run are fresh in your mind. All marks on the form must appear within the "boxes." *Data recorded here must match corresponding items on the 01A Narrative form for the patient*. No extra comments or writing should appear on the F-1612 data form, as the scanner will read the data incorrectly.

SEX (*Fieldname: GENDER*)

To show the patient's gender, mark the appropriate box **(M)ale, (F)emale** or **(U)nknown** (if the sex cannot be determined). **Do not mark more than one box**. The scanner reads a

DELETE

mark in the box for “M” that extends into the next box for “F” as a question mark, causing an error in the data.

AGE

Mark two numbers, **(0-9)**. Mark the numbers under the heading "Age" that match the number of whole years in the patient's age. If the patient is less than one year old, mark two zeroes ("00"). If they state the patient’s age as “18 months,” mark ("01") in the numbers below “Age.” If they state the patient’s age in half-years, for example as "two and a half," record only the whole number of years (marking the numbers "02"). If the patient is more than 99 years old, mark two nines ("99"). When the patient is obviously dead, attempt to get age from another party at the scene who knows the patient, or estimate the patient's age.

ZIP

Mark the numbers **(0-9)** beneath the heading "Zip" that represent the **first five digits of the patient's zip code**. If the patient is homeless or in transition or for some other reason has no zip code, make no marks in this section. For patients from outside the United States, mark 99999.

#PTS (*Fieldname:* PTS)

Record the number of patients encountered under the heading "# Pts" by marking the box with the appropriate number **(0-9)**. If you encounter more than nine patients at the scene, mark the box for ">9". Both the 01A Narrative form and F-1612 data form must be completed for each patient. This item is used to count multi-casualty incidents for statistical reporting. For example, a three-victim motor vehicle accident would have three forms, with "Number patients" marked "3" on each form--three different ICEMA numbers, with one incident number.

INCIDENT #

Mark eight boxes **(0-9)**. Using the dispatch number recorded on the *01A narrative under "Prim. Inc. #,”* mark the corresponding numbers below the heading for "Incident #." If the incident number is less than eight digits, mark zeroes to fill the boxes to the left of the incident number.

RUNDATE (*Fieldnames:* RUN-YEAR1 (9,0,1)/RUN-YEAR2 (0-9)/RUN-MONTH (0-9)/RUN-DAY (0-9))

Mark six boxes. Mark the numbers below the heading "rundate" that match the date written *in the "Date" area of the 01A Narrative*. Use 6-digit format and marking zeroes as necessary for the month and day, year, e.g., 06/01/02.

DELETE

DELETE

CITY

Mark three boxes **(0-9)**. Refer to the Incident City Codes listed on the back of the F-1612 data form. Find the three-digit code number across from the name of the city where the incident occurred. Mark the numbers beneath the heading "City" that represent this three-digit city code

RUN CODE (*Fieldnames:* RUN TO CODE/RUN FR CODE)
Definitions:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens
RUN TO CODE: Mark the number **(1, 2 or 3)** of run codes enroute to the scene. This should be the same number as that circled for *"Received Code" on the 01A Narrative*:
RUN FR CODE: Mark the number **(1, 2 or 3)** of run codes from the scene to the receiving. This should be the same number as circled for *"Depart Code" on the 01A Narrative*. If you make no transport, leave this item blank.

OTHER TRANSPORT PROVIDER/UNIT (*Fieldnames*: PROVIDER A/UNIT A)

Record the provider code **(0-9)** of another provider on scene. If your unit is the first on a scene and transfer patient care to another unit for transport, refer to the "Other Provider" area of the 01A Narrative. The transporting Provider Code list is on the back of the F-1612 data form. For fire departments, this code is "000." Record the 3-digit provider code and the unit number of the transporting unit. Complete this section only if a second unit is on scene and makes patient contact. **Use 777 for transport by any private car, truck, or other vehicle** that transports the patient (citizen transport). **Use 888 for transport by any provider that does not have an assigned code**, including transport by agencies outside the region.

TRANSP CODE1 (OTHER TRANSPORT)

Mark the type of unit **(MA, MS, ME, AM, SQ, E)** for another provider on scene. Enter this information only if a second unit is on scene and makes patient contact.

(MA) Medic Ambulance
(MS) Medic Squad
(ME) Medic Engine
(AM) Ambulance
(SQ) Squad
(E) Engine.

OTHER ICEMA# (*Fieldname:* ICEMA#1)

Enter another agency's O1A Narrative form number whenever another ALS provider agency is on scene and makes contact with the same patient. (*You mark their 01A number on your F-1612 data form, and they mark your 01A number on their F-1612 data form in the "Other ICEMA #" box*.) Fill this in whenever another 01A Narrative form exists for the same patient. If only one 01A form exists for a patient, this area should be blank.

PRIOR CARE

Mark the **one** appropriate box **(N, M, B, C, O, L, A)** to show the person or agent providing care or treatment to the patient prior to arrival of the prehospital field personnel completing this form.

1. **(N)none**: no care given to the patient prior to arrival of this unit.
2. **(M)medical**: a physician, nurse, or other medical person on a scene provided care.
3. **(B)FD/BLS**: a BLS unit provided prior care.
4. **(C)citizen**: a citizen, bystander, or relative provided care.
5. **(O)other**: Some person gave prior care not fitting any of the defined categories.
6. **(L)law enf.** police, sheriff, or other law enforcement personnel provided care.
7. **(A)FD/ALS**: another ALS unit provided prior care.

MECH. OF INJURY-TRAUMA ONLY (*Fieldname:* INJURY MECH)

Mark the space next to the **one** category **(M, C, G, S, A, D, F, B, L, T, E, P, O, U)** that best describes the mechanism of injury precipitating this call**. This section should be left blank for non-trauma cases**.

(M)auto/truck-MVA: any traffic incident, except those involving motorcycles. This includes an auto vs. an auto, auto vs. truck, pedestrian vs. autos, single vehicle collisions, etc.

SEATBELT: **(Y)es or (N)o** to show if the patient was wearing a seatbelt or other safety restraint device. Must be completed for all motor vehicle accident calls.

(C)motorcycle: any traffic related incident involving a motorcycle or bicycle. This includes autos vs. motorcycle, motorcycle vs. pedestrian, bicycle vs pedestrian, etc.

HELMET: **(Y)es or (N)o** to show if the patient was wearing a protective helmet. Must be completed for all traffic-related incidents involving motorcycles.

(G)gunshot: any call involving injury from a firearm, including a pistol, shotgun, rifle, or other similar weapon.

DELETE

(S)stabbing: a penetrating injury by a knife or other sharp object.

(A)assault: any injury resulting from assault other than a gunshot wound or stabbing.

(D)near-drowning: conditions resulting from submersion that deprives the patient of oxygen.

(F)fall >20' : injury resulting from a fall from a building, ladder, or other place estimated at more than 20 feet from the area where the patient landed. Do not use this category for slips or short-distance falls such as a fall in the bathtub. **For short falls, mark "blunt injury" or "penetrating injury"** as appropriate.

(B)bite/sting: injury from any type of animal, insect bite or sting; e.g., snakes, bee, a dog bite.

(L)blunt injury: an accidental injury in which the skin is unbroken or only slightly opened.

(T)multiple mech.: more than one mechanism of injury none more notable than another. If more than one mechanism, but one dominant injury occurs with other minor injuries, check the single category that caused the dominant injury.

(E)sports injury: an injury resulting from a sports related activity.

(P)oth penetrating: an injury other than stabbing which penetrates the skin and subcutaneous tissue.

(O)other: any condition not covered under the categories above, including ski, snow boarding and boating accidents.

(U)unknown: the mechanism of injury cannot be determined.

CATEGORY

Mark the **one** box **(T, C, R, A, B, 5, U, D, E, O, P, S, M, N)** next to the category that best fits this patient.

(T)trauma: any serious traumatic condition except cranial and/or spinal injury, assault involving domestic violence, or amputation. If you mark this box, you must **also mark "MECH. OF INJURY."** For **ski accidents**, mark this box and "**MECH OF INJURY" as (O)ther**.

(C)cardiac: all acute cardiopulmonary emergencies including myocardial infarction or suspected heart attack.

DELETE

(R)respiratory: choking incidents, asthma attacks, and other situations in which the patient's primary difficulty is failure to breathe adequately

(A)amputation: cases that involve potential re-implantation of a severed body part, cases involving complete or partial traumatic amputation of a body part.

(B)behavior/OD: intoxicated or psychologically disturbed patients, conditions related with alcohol or drug related syndromes including drug overdose, attempted suicide, and homicide victims; **does not include "5150" cases.**

(5)5150: patients transported to any mental health facility for 72-hour treatment and evaluation requested bylaw enforcement or other persons authorized to declare such treatment and evaluation

(U)burn: injury by fire, explosion, or chemical burn.

(D)domestic viol: calls involving child abuse or neglect, domestic partner abuse, elder abuse, or sexual assault. **Also specify "MECH. OF INJURY."**

(E)environment: diving casualties, radiation accidents, hypothermia, heat exhaustion, and other cases involving exposure to the elements. **Also specify "MECH. OF INJURY."**

(O)obstetric: problems relating to pregnancy, assistance with delivery, and postpartum emergencies.

(P)poisoning: emergencies resulting from ingestion, inhalation, or other exposure to toxic substances including intentional and accidental poisonings and hazardous materials' incidents; any call involving use of a poison control center.

(S)spinal inj: cranial and/or spinal trauma. **Specify "MECH. OF INJURY"**

(M)oth medical: other medical complaints such as diabetic complications, abdominal pain, or any medical problem involving a system other than the cardiac or respiratory system.

(N)transfer: any transfer of a patient from an acute care hospital to another facility.

BASE HOSP

Enter the base hospital code **(0-9)** only if BH was contacted. On the back of the F-1612 data form, find the name of the base hospital and the two-digit code next to the name. Mark the numbers corresponding to this code below the heading 'Base Hosp'.

DELETE

NO HOSPITAL CONTACT-USE CODE "89"

Mark (Y)es if no BH contact attempted/needed, RCF or contact was with receiving hospital only.

Note:

Base Hospital	No Contact	Interpreted As:
(blank)	Marked	no contact attempted/needed
Marked	Marked	radio communications failure (follow RCF protocol)
Marked	(blank)	successful base contact
(blank)	Marked	Contact with receiving hosp only.

RECV HOSP

On the reverse side of the F-1612 data form, find the name of the receiving hospital and mark the two-digit code number **(0-9)** here. Use code **"77" for all subacute or chronic care facilities** (e.g., nursing homes). Use code "**99" for destinations other than acute care hospitals, subacute or chronic care facilities** (e.g., a residence). If the patient refuses transport or if another provider is transporting the patient, leave this item blank.

TIMES

CALL RECD

Time call is first received by EMS Provider Agency. Mark the numbers **(0-9)** that match the *"Received" time from the 01A Narrative form.* Use military time (a 24-hour clock). Valid times range from 0000 (midnight) to 2359 (11:59 p.m.). DO NOT USE 2400. **Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

ENROUTE

Time that the response unit begins physical motion; i.e. wheels begin to turn. Mark the numbers **(0-9)** that match the *"Enroute" time from the 01A Narrative form*

ARRIVE (*Fieldname*: TIME ARRIVE)

Time the EMS unit stops physical motion at scene or staging area; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive" time from the 01A Narrative form*.

DEPART (*Fieldname:* TIME DEPART)

Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. . Mark the numbers **(0-9)** that match the *"Depart" time from the 01A Narrative form*. If you transport a patient, record DEPART as the time the ambulance

DELETE

leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARV DEST/END CALL (*Fieldname*: ARV DESTIN)

Time when patient arrives at destination or transfer point; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive Dest" time from the 01A narrative form.* Leave blank if your unit is not transporting the patient. Note: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.

PT REFUSES CARE (*Fieldname*: REFUSE CARE)

Mark this area **(Y)** when a patient declines **all** prehospital treatment. In such situations, the patient must also sign the medical release section on the back of the first copy of the 01A Narrative form. If the patient refuses one or more specific types of care, document the type of care refused in the Narrative/Assessment section of the 01A narrative form.

RELEASE SIGNED

Mark this box **(Y)** when the patient refuses treatment and completes the "Medical Liability Release Form" on the *back of the first copy (white) of the 01A Narrative form*.

MEDICATIONS (*Fieldname*: MEDICATION)

Mark as many boxes **(A, H, B, J, P, D, 1, 2, E, Q, F, G, I, L, R, S, M, N, 3, W, C, 4, V, U)** as apply. Mark ONLY the box(es) given by the unit recording this run. The medications are listed alphabetically; **(A)act. charcoal, (H)adenosine, (B)albuterol, (J)aspirin, (P)atropine, (D)dextrose, (1)diphenhydram, (2)dopamine, (E)epineph-IV, (Q)epineph-SQ, (F)furosemide, (G)glucagon, (I)ipratropium bromide ATROVENT, (L)lidocaine, (R)magnesium, (S)midazolam, (M)morphine, (N)naloxone, (3)nitroglycerine, (W)phenylephrine, (C)procainade, (4)sodium bicarb, (V)verapamil, (U)other med, for medication(s) administered but not listed.** For Interfacility Transfers, mark boxes for medication that are being monitored by the EMT-P during the transfer.

CARE RENDERED (*Fieldnames*: CARE1/CARE2)

For service or treatment provided, mark as many boxes as apply in the BLS (left column) **(F, A, M, B, P, D, E, C, H, K, N, O, X, G, I, S, T, L, W, U)** or ALS (right column) **(B, I, D, E, T, J, F, G, 1, 2, 3, 4, O, P, N, C, K, Y, H, V, U)**. Mark each treatment or procedure only once, though it may have been done for this patient several times. Mark only those services provided by your unit. Document services provided by non-EMS individuals or other agencies in the "Narrative/Assessment" section of the 01A form. Other agencies

DELETE

must document services provided by their agency on their O1A form and F-1612 data form.

BLS SERVICES(*Fieldname*: CARE 1):(Care Rendered [Left Column])

(F)AED: when used on patient

(A)bag-valve mask: on resuscitation

(M)burn care: on burns

(B)axial spinal stabilization: on patient

(P)CPR/resuscitation: when preformed on patient

(D)decontamination: usually associated with exposure to hazardous materials

(E)extrication: from a vehicle or hazardous situation; if time > than 10 minutes, record the approx. time in the Narrative/Assessment section of the 01A form

(C)hard collar: to immobilize the neck

(H)hot/cold packs: on patient

(K)KED: on patient

(N)NP/OP airway: on attempts to establish a nasopharyngeal or oral pharyngeal airway

(O)OB assist: on assistance with obstetrical delivery

(X)oxygen: on administration to patient

(G)sand bags: used for patient

(I)snake bite kit: on patient

(S)splint, simple: on patient

(T)splint, traction: on patient

(L)suction: on patient

(W)wound dressing: on patient

DELETE

(U)BLS Other: for a BLS procedure other than those listed

ALS SERVICES (*Fieldname*: CARE 2):(Care Rendered [Right Column])

(B)blood drawn: on patient

(I)CPAP: on patient

(D)dexstick: on patient

(E)ECG monitor: on patient (**also mark the "1 ST ECG" section**)

(T)ECG strip: on patient

(F)12 lead ECG: on patient

(G)McGill forceps: on an attempted or performed foreign body removal

(1)Meds given IV: route given to pt

(2)Meds given IO: route given to pt

(3)Meds given ET: route given to pt

(4)Meds given PO: route given to pt

(O)monitor chest tubes: on an attempted, inserted a chest tube, or monitored

(P)needle thoracostomy: on an attempted or performed needle thoracostomy

(N)NG insertion: on an attempted, inserted or monitored NG tube

(C)Percutaneous Needle Cric: if attempted, or inserted

(Q)Pulse Ox: on patient

(Y)Approved Device: Quick Trach Device

(H)TCP: if attempted or placed

(V)Valsalva maneuver: on patient

(U)ALS Other:for an ALS procedure other than those listed, for transfer patients mark this box if EMT-P is monitoring IV medication during the transfer.

DELETE

SYS BP

Mark the box **(4-0)** next to the category in which the patient's initial systolic blood pressure reading falls. If no systolic BP is present, mark the space for "0." Blood pressures are usually obtainable on pediatric patients with a pediatric BP cuff. If you obtain no BP, leave this area blank. **LIST ONLY VITAL SIGNS TAKEN BY YOUR AGENCY**.

RESP RATE

Using the **first** observation of the patient's respiratory rate, mark the box **(4-0)** next to the category in which the patient's rate (in number of respiration's per minute) occurs. For example, if the patient's respiration rate is 20, mark the top space, numbered 4.

EFFORT

Referring to **initial** respiratory effort (chest wall movement), mark the box **(1 or 0)** next to the category that better describes the situation for this patient~normal, or shallow/refractive/none.

CAP REFILL

Mark the box **(2, 1, 0)** that best describes the patient's capillary refill upon **initial assessment**.

BEST MOTOR (*Fieldname*: MOTOR)

Mark the box **(6-1)** next to the patient's **initial** best motor response.

BEST VERBAL (*Fieldname*: VERBAL)

Mark the box **(5-1)** next to the category that describes this patient's **initial** best verbal response.

EYE OPEN
Note the patient's **initial** ability to open his/her eye(s). Mark the box **(4-1)** next to the category**.**

(R)cardiovert (D)defib (*Fieldname*: D-FIB)
Mark **(R)CARDIOVERT (D)DEFIB** if performed by the unit recording this run.

1ST ECG
Mark **one** box **(N, B, T, V, C, D, I, L, E, A, Y, O)** for the code of the **first rhythm detected** on EKG by unit recording this run, *as recorded on the 01A Narrative*.

DELETE

DELETE

(N)SR: Normal sinus rhythm
(B)SB: Sinus bradycardia; heart rate <60 beats per minute
(T)ST: Sinus tachycardia; heart rate >100 per minute
(V)Vfib: Ventricular fibrillation
(C)VT: Ventricular tachycardia (V tach)
(D)SVT: Super ventricular tachycardia
(I)Afib: Atrial fibrillation
(L)AFL: Atrial flutter
(E)AT: Atrial tachycardia
(A)AVB: Atrioventricular block (AV block) or heart block
(Y)ASY: Asystole
(O)Oth Unidentifiable rhythm

ATTEMPTS PLACED
IV (*Fieldnames*: IV ATTEMPT/IV2 ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place IV needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IV's, the number of IV attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IV took two tries before placement, mark "2," etc.

IO (*Fieldnames*: IO ATTEMPT/IO2 ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place IO needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IO's, the number of IO attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IO took two tries before placement, mark "2," etc.

ET (*Fieldnames*: ET1 ATTEMPT/ET1A ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place tube. If successful mark **(Y).**

ET-NASAL (*Fieldname*: ET2 ATTEMPT)

Indicate placement of ET: **(N)**nasal or **(O)**oral.

PT CONDITION

Mark the patient's overall response to treatment. BLANK IS INVALID. This category refers to the patient's response to all treatment rather than to a specific drug or procedure. Mark **(C)changed** or **(N)no change** during transport.

DELETE

IV/IO

Mark box for saline or **(S)** OR **(L)**

SPECIAL STUDY

Use this area whenever a special study is conducted. Mark all boxes **(M, S, or O)** that apply.

(M)Medications
(S)Skills
(O)other.

OUTCOME

Mark the box **(C, D, R, G, A, O)** next to the category that best describes this call. *BLANK IS INVALID*.

(C)canceled enroute: Call canceled by agency dispatcher prior to arrival at a scene and if the run is canceled on scene before you make pt contact.

(D)dry run-no pt No patient was found at the scene, the unit was unable to locate the scene or the patient, or the patient refuses to communicate so you cannot obtain any patient information.

(R)transport refused: The patient accepted care by an EMS field provider but refused to be transported by any EMS provider, and for walk-in patients.

(G)transport-ground: Patient received prehospital care, was transported by this or another ground ambulance, or if patient care was transferred to another unit.

(A)transport-air: Patient received prehospital care, was transported by helicopter or fixed-wing aircraft, and for patient to loading zone and patient care to EMS air.

(O)obviously dead: Patient showed obvious signs of death, per protocol.

WHY SELECTED

Mark the category **(S, T, P, D, C, E, R, O)** that most closely matches the reason for selection of the receiving hospital. If the base hospital indicates a reason, mark the hospital's determination of "why selected."

(S)Stemi: a stemi center is required.

(T)major trauma: a trauma center is required.

(P)patient request: patient or patient's physician requests transport to a specific facility

(D)diversion: the original receiving hospital selected was on diversion

(C)closest: the hospital is closest to the scene.

(E)peds trauma: pediatric trauma center is required.

(R)reroute: the receiving hospital destination changed while the unit was enroute (e.g., a change in patient condition required selection of a different facility). Does not include change in a destination based upon hospital status

(O)other: a reason other than those listed was used in selecting the receiving hospital.

ICEMA# (*Fieldname*: ICEMA#2)

Mark six boxes **(0-9**) to indicate the ICEMA number printed on the upper left corner of the 01A Narrative form for this patient. An ICEMA number is required here, **except for dry runs or canceled calls**.

ATTENDANT #1 CERT NO (*Fieldnames*: CERT#1A/CERT#1B)

Mark the first box **(E, L, P, or M)** to indicate the level of accreditation/certification for primary patient caregiver reporting on this run. P for paramedic, E for emergency medical technician, or M for mobile intensive care nurse (on interfacility transfers). Mark the ICEMA accreditation/certification numbers **(0-9)** in the remaining boxes**.** If your ICEMA number is less than five digits, use leading zeroes before the number as needed to fill the boxes. **Provisional paramedics or MICNs who are third members of the ambulance crew sign the 01A narrative form, but enter no data on the F-1612 data form.**

ATTENDANT #2 CERT NO (*Fieldnames*: CERT#2A/CERT#2B)

Mark the first box **(E, L, P, or M)** to indicate the type of accreditation/certification for the secondary patient caregiver reporting on this run. Mark the ICEMA accreditation/certification number **(0-9)** in the remaining boxes. If your number is less than five digits, use leading zeroes before the number as needed to fill the boxes

THIS FORM BY PROVIDER/UNIT (*Fieldnames*: PROVIDER B/UNIT B)
Obtain your 3-digit provider code from the list on the back of the F-1612 data form. Mark the box with these three digits **(0-9)** below "Provider." For all agencies, mark three

DELETE

numbers that represent the unit number of the vehicles in which you are riding on this call. Use leading zeroes.

TRANSP CODE2 (THIS FORM BY)
Enter the type of unit for the agency reporting this run.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine

REVERSE SIDE OF F-1612 DATA FORM

PUBLIC PROVIDERS

Fire department EMS providers, use provider code followed by the unit type (MA, ME, MS, AM, SQ, E) and three-digit unit number as assigned by Fire Chiefs. **Use code 888 for other Public Providers outside the ICEMA region**.

PRIVATE PROVIDERS

A three-digit code is assigned to each private ALS or BLS provider agencies within the region. Provider codes are used in the area for "Other Transport Provider" on the F-1612 data form (upper right corners) as well as for the "This Form By" provider code in the lower right corner. Codes are organized alphabetically by county. The provider code is followed by a three-digit unit number assigned by ICEMA, e.g., 001. **Use code 999 for other Private Providers outside the ICEMA region.**

HOSPITAL CODES

Two-digit code numbers have been assigned to each hospital within the ICEMA region. These codes are used in the "Base Hospital" and "Receiving Hospital" areas of the F-1612 data form. They are listed alphabetically by hospital name. **Use code 88 for all hospitals outside the ICEMA region**.

INCIDENT CITY CODES

These three-digit code numbers are to be used to complete the "City" area in the upper right portion of the F-1612 data form. To find a code, first locate the section of the form for the appropriate county within the region (Inyo, Mono, or San Bernardino). For San Bernardino County, check the subheadings for the appropriate geographical area (e.g., West Valley or High Desert). Cities and communities are listed alphabetically within the county or area.

DELETE

If the city or community where the incident occurred is not listed, use the code for the city or community nearest to the incident location; if none, use the code for "Inyo Co. Other," "Mono Co. Other," or "San Bernardino Co. Other," as appropriate

DELETE

BLS/LALS/ALS STANDARD DRUG & EQUIPMENT LIST

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

All ALS (transport and non-transport) and BLS transport vehicles shall be inspected annually.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Adenosine (Adenocard) 6 mg			1	1
Adenosine (Adenocard) 12 mg			2	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg		4 doses	4 doses	4 doses
Albuterol MDI with spacer		1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY
Aspirin, chewable - 81 mg tablet		2	1 bottle	1 bottle
Atropine 1 mg preload			2	2
Calcium Chloride 1 gm preload			1	1
Dextrose 10% in 250 ml Water (D10W) *		2	2	2
Diphenhydramine (Benadryl) 50 mg			1	1
Dopamine 400 mg			1	1
Epinephrine 1:1000 1 mg		2	2	2
Epinephrine 1:10,000 1 mg preload			3	3
Glucagon 1 mg		1	1	1
Glucose paste	1 tube	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg			4	4
Irrigating Saline and/or Sterile Water (1000 cc)	2	1	1	2
Lidocaine 100 mg			3	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W			1	1
Lidocaine 2% Intravenous solution			1	1
Lidocaine 2% (Viscous) dose			1	1
Magnesium Sulfate 10 gm			1	1
Naloxone (Narcan) 2 mg preload		2	2	2
Nitroglycerine - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening)		2	1	2
Normal Saline for Injection (10 cc)		2	2	2

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Normal Saline 100 cc			1	2
Normal Saline 250 cc			1	1
Normal Saline 500 ml and/or 1000 ml		2000 ml	3000 ml	6000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)			4	4
Ondansetron (Zofran) 4 mg IM/ IV			4	4
Phenylephrine HCL - 0.5 mg per metered dose			1 bottle	1 bottle
Sodium Bicarbonate 50 mEq preload			2	2

CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange Controlled Substance Medications MUST BE DOUBLE LOCKED	BLS	LALS	ALS Non-Transport	ALS Transport
Fentanyl			200-400 mcg	200-400 mcg
Midazolam			20-40mg	20-40mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
BAAM Device			1	2
CPAP circuits - all manufacture's available sizes	1 (if CPAP is carried)	1 (if CPAP is carried)	1 each	2 each
End-tidal CO2 device - Pediatric and Adult (may be integrated into bag)			1 each	1 each
Endotracheal Tubes cuffed - 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet			2 each	2 each
ET Tube holders - adult		1 each	1 each	2 each
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	2 each SPECIALTY PROGRAMS ONLY	1 each	1 each	2 each
King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange)	2 each SPECIALTY PROGRAMS ONLY	1 each	1 each	2 each
Mask - Adult & Pediatric non-rebreather oxygen mask	2 each	2 each	2 each	2 each
Mask - Infant Simple Mask	1	1	1	1
Nasal cannulas - pediatric and adult	2 each	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr			1 each	1 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr			1 each	1 each
Nasopharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Needle Cricothyrotomy Device - Pediatric and adult or Needles for procedure 10, 12, 14 and/or 16 gauge			1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent			1	1

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Oropharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Rigid tonsil tip suction	1		1	1
Small volume nebulizer with universal cuff adaptor		2	2	2
Suction Canister	1		1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each		1 each	1 each
Ventilation Bags -				
Infant 250 ml	1	1	1	1
Pediatric 500 ml (or equivalent)	1	1	1	1
Adult	1	1	1	1
Water soluble lubricating jelly		1	1	1

Non-Exchange Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Ambulance oxygen source -10 L /min for 20 minutes	1			1
Flashlight/penlight	1	1	1	1
Laryngeal blades - #3, #4 curved and/or straight			1 each	1 each
Laryngoscope handle with batteries - or 2 disposable handles			1	1
Magill Forceps - Pediatric and Adult			1 each	1 each
Manual powered suction device		1		
Portable oxygen with regulator - 10 L /min for 20 minutes	1	1	1	1
Portable suction device (battery operated)	1		1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1	1
Stethoscope	1	1	1	1
Wall mount suction device	1 (BLS TRANSPORT ONLY)			1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Conductive medium or Pacer/Defibrillation pads			2 each	2 each
Disposable Tourniquets		2	2	2
ECG electrodes			20	20
EZ-IO Driver			1 each	1 each
EZ-IO Needles: 25 mm 45 mm			 2 each 1 each	 2 each 1 each
Glucose monitoring device with compatible strips and OSHA approved single use lancets		1	1	1
3-way stopcock with extension tubing			2	2
IV Catheters - sizes 14, 16, 18, 20, 22, 24		2 each	2 each	2 each
Macrodrip Administration Set Microdrip Administration Set (60 drops /cc)		3 1	3 1	3 2
Mucosal Atomizer Device (MAD) for nasal administration of medication		2	2	4
Pressure Infusion Bag (disposable)		1	1	1
Razors		1	2	2
Safety Needles - 20 or 21gauge and 23 or 25 gauge		2 each	2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2	2
Sterile IV dressing		2	2	2
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc catheter tip		2 each		
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc, 20 cc, 60 cc catheter tip			2 each	2 each

Non-Exchange IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
12-lead ECG Monitor and Defibrillator with TCP and printout			1	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant (one of each size)	1	1	1	1
Capnography monitor and supplies, may be integrated in the cardiac monitor			1	1
Needle disposal system (OSHA approved)		1	1	1
Thermometer - Mercury Free with covers	1	1	1	1

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	LALS	ALS Non-Transport	ALS Transport
AED/defib pads - Adult (1), Pediatric (1)	1 each	1 each		
Ammonia Inhalants			2	2
Automatic CPR device (FDA approved)	1	1	1	1
Automatic ventilator (ICEMA approved)			1	1
Backboard padding	1	1	1	1
Buretrol			1	1
Chemistry profile tubes			3	3
CPAP - (must be capable of titrating pressure between 2 and 15 cm H_2O)	1 (optional)	1 (optional)	1	1
CyanoKit (Specialty Program Only)			1	1
EMS Tourniquet	1		1	1
Endotracheal Tubes, cuffed - 2.5, 3.0, 3.5 with stylet			SPECIALTY PROGRAMS ONLY	SPECIALTY PROGRAMS ONLY
Endotracheal Tubes, cuffed - 4.0 or 4.5, 5.0 or 5.5 with stylet			SPECIALTY PROGRAMS ONLY	SPECIALTY PROGRAMS ONLY
Gum Elastic intubation stylet			2	2
Hemostatic Dressings *	1	1	1	1
IO Needles - Manual, Adult and Pediatric, Optional		Pediatric sizes only or EZ-IO needles and drivers	1 each	1 each
IV infusion pump			1	1
IV warming device		1	1	1
Manual IV Flow Rate Control Device			1	1
Manual powered suction device	1	1	1	1
Multi-lumen peripheral catheter			2	2
Needle Thoracostomy Kit (prepackaged)			2	2
Pulse Oximetry device	1			
Translaryngeal Jet Ventilation Device			1	1
Vacutainer			1	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4”x4”pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Exchanged Dressing Materials/Other Equipment/Supplies	**BLS**	**LALS**	**ALS Non-Transport**	**ALS Transport**
Adhesive tape - 1 inch	2	2	2	2
Air occlusive dressing	1	1	1	1
Ankle and wrist restraints, soft ties acceptable	1		1	1
Antiseptic swabs/wipes		10	10	10
Bedpan or fracture pan Urinal	1(BLS TRANSPORT UNITS ONLY 1(BLS TRANSPORT UNITS ONLY			1 1
Cervical Collars - Rigid Pediatric and Adult all sizes or Cervical Collars - Adjustable Adult and Pediatric	2 each 2 each	2 each 2 each	2 each 2 each	2 each 2 each
Cold Packs	2	2	2	2
Emesis basin or disposable bags and covered waste container	1	1	1	1
Head immobilization device	2	2	2	2
OB Kit	1	1	1	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	2	4
Provodine/Iodine swabs/wipes or antiseptic equivalent		4	10	10
Roller bandages - 4 inch	6	3	3	6
Sterile bandage compress or equivalent	6	2	2	6
Sterile gauze pads - 4x4 inch	4	4	4	4
Sterile sheet for Burns	2	2	2	2
Universal dressing 10x30 inches	2	2	2	2

Non-Exchange Dressing Materials/Other Equipment/Supplies	**BLS**	**LALS**	**ALS Non-Transport**	**ALS Transport**
800 MHz Radio		1	1	1
Ambulance gurney	1(BLS TRANSPORT UNITS ONLY			1
Bandage shears	1	1	1	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2	1	2	2
Drinkable water in secured plastic container or equivalent	1 gallon			1 gallon
Long board with restraint straps	1	1	1	1
Pediatric immobilization board	1	1	1	1
Pillow, pillow case, sheets and blanket	1 set (BLS TRANSPORT UNITS ONLY			1 set

Non-Exchange Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
Short extrication device	1	1	1	1
Straps to secure patient to gurney	1 set (BLS TRANSPORT UNITS ONLY			1 set
Traction splint	1	1	1	1
Triage Tags - CAL Chiefs or ICEMA approved	20	20	20	20

EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

MEDICATIONS/SOLUTIONS	AMOUNT
Adenosine (Adenocard) 6 mg	1
Adenosine (Adenocard) 12 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg	3 doses
Aspirin, chewable - 81 mg tablet	1 bottle
Atropine 1 mg preload	2
Calcium Chloride 1 gm preload	1
Dextrose 10% in 250 ml Water (D10W) *	2
Diphenhydramine (Benadryl) 50 mg	1
Dopamine 400 mg	1
Epinephrine 1:1,000	2
Epinephrine 1:10,000	2
Glucagon 1 mg	1
Glucopaste	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg	3
Lidocaine 100 mg	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W	1 gm
Lidocaine 2% Intravenous solution	1
Lidocaine 2% (Viscous)	1 dose
Magnesium Sulfate 10 gms	1
Naloxone (Narcan) 2 mg preload	2
Nitroglycerin - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening.)	1
Normal Saline for Injection (10 cc)	2
Normal Saline 250 ml	1
Normal Saline 500 ml and/or 1000 ml	2000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5 mg per metered dose	1 bottle
Sodium Bicarbonate 50 mEq preload	2

CONTROLLED SUBSTANCE MEDICATIONS-MUST BE DOUBLE LOCKED	AMOUNT
Fentanyl	200-400 mcg
Midazolam	20-40 mg

AIRWAY/SUCTION EQUIPMENT	AMOUNT
Aircraft Oxygen source -10 L /min for 20 minutes	1
BAAM Device	1
C-PAP circuits - all manufacture's available sizes	1 each
End-tidal CO2 device - pediatric and adult (may be integrated into bag)	1 each
Endotracheal Tubes cuffed - 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet	2 each
ET Tube holders - adult	1 each
Flashlight/penlight	1
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	1 each
King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange)	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1
Laryngeal blades - #3, #4 curved and/or straight	1 each
Magill Forceps - Pediatric and Adult	1 each
Nasal Cannulas - infant, pediatric and adult	2 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Nasopharyngeal Airways - infant, child, and adult	1 each
Needle Cricothyrotomy Device (Approved) - Pediatric and adult *or* Needles for procedure 10, 12, 14 and/or16 gauge	1 each 2 each
Non Re-Breather O_2 Mask - Pediatric and Adult, Infant Simple Mask	2 each
One way flutter valve with adapter or equivalent	1
Oropharyngeal Airways - infant, child, and adult	1 each
Portable Oxygen with regulator - 10 L /min for 20 minutes	1
Portable suction device (battery operated) *and/or* Wall mount suction device	1 each
Pulse Oximetry device	1
Small volume nebulizer with universal cuff adaptor	1
Stethoscope	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags - Infant 250 ml, Pediatric 500 ml and Adult 1 L	1 each
Water soluble lubricating jelly	1
Ridged tonsil tip suction	1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT	AMOUNT
12-Lead ECG Monitor and Defibrillator with TCP and printout	1
800 MHz Radio	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant	1 set
Capnography monitor and supplies, may be integrated in the cardiac monitor	1
Conductive medium *or* Adult and Pediatric Pacer/Defibrillation pads	2 each
ECG - Pediatric and Adult	20 patches
EZ IO Needles and Driver 25 mm and 45 mm	2 each 1 each
3-way stopcock with extension tubing	2
IO Needles - Manual, Adult and Pediatric, Optional	1 each
IV Catheters - sizes 14, 16, 18, 20, 22, 24	2 each
Glucose monitoring device	1
Macrodrip Administration Set Microdrip Administration Set (60 drops/ml)	3 1
Mucosal Atomizer Device (MAD) for nasal administration of medication	4
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Safety Needles - 20 or 21 gauge and 23 or 25 gauge	2 each
Saline Lock	2
Syringes w/wo safety needles - 1 ml, 3 ml, 10 ml, 20 ml	2 each
Syringe - 60 ml catheter tip	2
Thermometer - Mercury free with covers	1

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Adhesive tape - 1 inch	2
Air occlusive dressing	1
Aircraft stretcher or litter system with approved FAA straps that allows for Axial Spinal Immobilization	1
Ankle and wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Bandage shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2
Cervical Collars - Rigid Pediatric & Adult all sizes *or* Cervical Collars - Adjustable Adult and Pediatric	1 each 1 each
Emesis basin or disposable bags and covered waste container	1
Head immobilization device	1
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4
Provodine/Iodine swabs/wipes or antiseptic equivalent	
Roller bandages - 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads - 4x4 inch	4

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Sterile Sheet for Burns	2
Traction splint	1
Universal Dressing 10x30 inches	2

OPTIONAL EQUIPMENT/MEDICATIONS	Amount
Ammonia Inhalants	2
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
Chemistry profile tubes	3
CyanoKit (Specialty Program Only)	SPECIALTY PROGRAMS ONLY
D5W in bag	1
Hemostatic Dressing *	1
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Medical Tourniquet	1
Needle Thoracostomy Kit (prepackaged)	2
Pediatric immobilization board	1
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, and 4”x4” pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

MEDICATION - STANDARD ORDERS

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)

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 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 IV/IO slow IV push over three (3) to four (4) minutes.

Magnesium Sulfate, 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/IM/IN
9 to 14 years	Naloxone, 0.5 mg IV/IO/IM/IN

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_2 at 94%.
Do not administer supplemental oxygen for $SPO_2 > 95\%$

Chronic Obstructive Pulmonary Disease (COPD):

Titrate Oxygen at lowest rate required to maintain SPO_2 at 90%
Do not administer supplemental oxygen for $SPO_2 > 91\%$

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

Sodium Bicarbonate (ALS) (base hospital order only)

Tricyclic Poisoning:
Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #s 2020, 7010, 7020, 13010

INTERFACILITY TRANSFER GUIDELINES

I. PURPOSE

To identify patient care responsibilities for emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics (EMT-Ps) during interfacility transports.

II. BLS INTERVENTIONS

During an interfacility transport, an EMT may monitor the following if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via BLS ambulance:

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

- Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
  - No medications have been added to the IV fluid.
  - Maintain the IV at a pre-set rate.
  - Check tubing for kinks and reposition arm if necessary.
  - Turn off IV fluid if signs/symptoms of infiltration occur.
  - Control any bleeding at insertion site.
- Transport a patient with a urinary catheter provided the following:
  - The catheter is able to drain freely.
  - No action is taken to impede flow or contents of drainage collection bag.
- Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped.
- If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

III. LIMITED ALS (LALS) INTERVENTIONS

During an interfacility transport, if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via LALS ambulance, an AEMT may monitor or perform the following:

- Peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Saline locks.
- Tracheo-bronchial suction of an intubated patient.
- Initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

AEMTs may not transport a patient with IV drips that are not in the AEMT scope of practice.

AEMTs may not transport patients with blood or blood products.

IV. ALS INTERVENTIONS

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

If the transfer is a STEMI patient, refer to ICEMA Reference#8040 - Continuation of Care of a STEMI Patient (San Bernardino Only).

EMT-Ps may not transport a patient with IV drips that are not in the EMT-P scope of practice.

EMT-Ps may not transport patients with blood or blood products.

During an interfacility transport, an ICEMA accredited EMT-P may:

- Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.

- Transport intravenous solutions with added medication(s) as follows:
  - Lidocaine
  - Dopamine
  - Magnesium Sulfate
- Monitor and administer medications through a pre-existing vascular access.
- Monitor heparin lock or saline lock.
- Monitor IV solutions containing potassium ≤40mEq/L.
- Monitor thoracostomy tubes to water or dry sealed drainage.
- Monitor nasogastric tubes.
- EMT-Ps may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

V. NURSE ASSISTED ALS TRANSPORT

In the event of a critical patient that needs transport with medication or IV drips that are outside of the EMT-P scope of practice and CCT transport is not possible, a Registered Nurse (RN) from the transferring hospital may accompany the patient. The RN will be responsible for orders from the transferring physician. In the event the patient condition deteriorates, the EMT-P will contact the Base Station for orders and destination change. The RN will continue to provide care consistent with the transferring physician's orders. The Base Station physician may consider discontinuing or continuing the prior orders based on patient condition. The RN will document the Base Station physician orders on the transferring facility's patient care record. The EMT-P will document on the ePCR or O1A.

VI. REFERENCES

Number	Name
5040	Radio Communication Policy
8040	Continuation of Care of a STEMI Patient (San Bernardino Only)

FORT IRWIN CONTINUATION OF 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.

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.

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.

c. SPECIAL CONSIDERATIONS

- 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 Integrillin 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

a. Fort Irwin maintains internal 24-hour US Army Air Ambulance with MEDEVAC capabilities conducted by C Company (Air Ambulance), 2916th 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 <u>not</u> required. These patients will bypass WACH and proceed directly to a SRC, NSRC or TC for treatment.

b. 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.

c. 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 <u>not</u> 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

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

CONTINUATION OF CARE

(San Bernardino County Only)

I. PURPOSE

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

This policy shall only be used for:

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

It is <u>not</u> to be used for any other form of interfacility transfer of patients.

II. DEFINITIONS

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

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

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

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

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

III. INCLUSION CRITERIA

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

- Any patient with a positive STEMI requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and 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 Criteria and Destination Policy).

IV. INITIAL TREATMENT GOALS AT RH

- Initiate resuscitative measures within the capabilities of the facility.

- Ensure patient stabilization is adequate for subsequent transport.

- <u>Do not delay transport</u> by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

  - GUIDELINES

    < 30 minutes at RH (door-in/door-out).
    < 30 minutes to complete ALS continuation of care transport.
    < 30 minutes door-to-intervention at Specialty Care Center.

- RH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. Refer to Section IV - SRH-SRC Buddy System Table.

- EMS providers shall make Specialty Care Center base hospital contact.

- The Specialty Care Centers shall accept all referred trauma, stroke and STEMI patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).

- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal Trauma, STEMI, or Stroke Team according to internal TC, SRC or NSRC policies or protocols.

- RH ED physician will determine the appropriate mode of transportation for the patient.

- Simultaneously call 9-1-1 and utilize the following script to dispatch:

  "This is a Continuation of Care run from ____hospital to ____Trauma, STEMI or Stroke Center"

  Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

- RH ED physician will provide a verbal report to the ED physician at the Specialty Care Center.

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

V. SPECIAL CONSIDERATIONS

- If the patient has arrived at the RH via EMS field personnel, the RH ED physician may request that the transporting team remain and immediately transport the patient once minimal stabilization is done at the RH.

- If a suspected stroke patient is outside of the tPA administration window (greater than 4.5 hours from "last seen normal"), contact nearest stroke center to determine the best destination. Then follow the 9-1-1 script.

- EMT-Ps may only transport patients on Dopamine and Lidocaine drips. Heparin and Integrillin drips are not within the EMT-P scope of practice and require a critical care transport nurse to be in attendance. Unless medically necessary, avoid using medication drips that are outside of the EMT-P scope of practice to avoid any delays in transferring of patients.

- The RH may consider sending one of its nurses or physician with the transporting ALS unit if deemed necessary due to the patient's condition or scope of practice.

- Requests for Specialty Care Transport (SCT) (ground or air ambulance) must be made directly with the EMS provider's dispatch center. The request for SCT should be made as early as possible or simultaneously upon patient's arrival so availability of resource can be determined.

- Specialty Care Center diversion is not permitted except for Internal Disaster. However, Specialty Care Center base hospitals are allowed to facilitate redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to avoid prolonged door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

VI. SPECIALTY CARE CENTER - REFERRAL HOSPITAL BUDDY SYSTEM TABLE

NEUROVASCULAR STROKE RECEIVING CENTERS (NSRC)	NEUROVASCULAR STROKE REFERRAL HOSPITALS (NSRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Colorado River Medical Center • Community Hospital of San Bernardino • Hi Desert Medical Center • St. Bernardine Medical Center • St. Mary Medical Center
Desert Regional Medical Center	• Colorado River Medical Center • Hi-Desert Medical Center
Kaiser Hospital Foundation - Fontana	• Barstow Community Hospital • Victor Valley Global Medical Center • Desert Valley Hospital
Kaiser Hospital Foundation - Ontario	• Chino Valley Medical Center • Montclair Community Hospital
Loma Linda University Medical Center	• Bear Valley Community Hospital • Community Hospital of San Bernardino • J.L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital • St. Bernardine Medical Center • Weed Army Community Hospital at Fort Irwin
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
Redlands Community Hospital	• Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital
San Antonio Regional Hospital	• Chino Valley Medical Center • Desert Valley Hospital • Montclair Hospital Medical Center • St. Mary Medical Center • Victor Valley Global Medical Center

STEMI RECEIVING CENTER (SRC)	STEMI REFERRAL HOSPITAL (SRH)
Desert Valley Hospital	• Barstow Community Hospital • Victor Valley Global Medical Center • Weed Army Community Hospital at Fort Irwin
Loma Linda University Medical Center	• Arrowhead Regional Medical Center • Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Redlands Community Hospital
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
San Antonio Regional Hospital	• Chino Valley Medical Center • Kaiser Ontario Medical Center • Montclair Hospital Medical Center
St. Bernardine Medical Center	• Colorado River Medical Center • Community Hospital of San Bernardino • Kaiser Fontana Medical Center • Mountains Community Hospital
St. Mary Medical Center	• Barstow Community Hospital • Bear Valley Community Hospital • Hi-Desert Medical Center • Robert E. Bush Naval Hospital-29 Palms • Victor Valley Global Medical Center

TRAUMA CENTER (TC)	REFERRAL HOSPITAL (SRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Chino Valley Medical Center • Desert Valley Medical Center • Kaiser Fontana • Kaiser Ontario • Mammoth Hospital • Montclair Hospital Medical Center • Northern Inyo Hospital • San Antonio Regional Hospital • Southern Inyo Hospital • St. Bernardine Medical Center
Loma Linda University Medical Center	• Bear Valley Community Hospital • Colorado River Medical Center • Hi Desert Medical Center • Mountains Community Hospital • Redlands Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Robert E. Bush Naval Hospital-29 Palms • St. Mary Medical Center • Victor Valley Global Medical Center • Weed Army Hospital
Loma Linda University Children's Hospital	• Regional Pediatric Trauma Center

VII. REFERENCES

Number	**Name**
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy
6100	Neurovascular Stroke Receiving Centers Destination Policy (San Bernardino County Only)
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)
15030	Trauma Triage Criteria

GENERAL PATIENT CARE GUIDELINES

I. PURPOSE

To establish guidelines for the minimum standard of care and transport of patients.

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. Skeletal or soft tissue injuries.
3. Acute or chronic injury or disease process.
4. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
5. Evidence that the individual was subject to force that may cause injury.
6. Other condition that warrants evaluation and care at an acute care hospital.

Patient Contact: Determined to occur when any on duty BLS, LALS, or ALS field personnel (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 controlled substances).

IV. LIMITED ALS (LALS) INTERVENTIONS

1. Evaluation and continuation of all initiated BLS care.

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.

2. Augment BLS and/or LALS assessment with clinically indicated advanced assessments including but not limited to the following:

   a. Cardiac monitor and/or 12-lead ECG.

   b. Capnography.

   c. Blood glucose monitoring.

3. Augment BLS and/or LALS treatment with advanced treatments as clinically indicated.

   a. Initiate airway control using an appropriate airway adjunct to achieve adequate oxygenation and ventilation.

   b. Initiate airway control only when clinically indicated for the appropriate administration of medications and/or fluids.

4. Review and evaluate treatments initiated by BLS, LALS, or ALS personnel.

   a. Consider discontinuing treatments not warranted by patient's clinical condition. Intermittent monitoring may be used instead of continuous monitoring when clinically indicated.

PROCEDURE - STANDARD ORDERS

12-lead Electrocardiography (EMT-P)

- ECG should be performed prior to medication administration.
- ECG should be performed on any patient whose medical history and/or presenting symptoms are consistent with acute coronary syndrome including typical or atypical chest pain, syncopal episode, prior AMI, heart disease, or other associated risk factors.

Axial Spinal Immobilization (EMT, AEMT and EMT-P)

- Should be placed if patient meets the indicators , per ICEMA Reference #15010 - Trauma - Adult (Neuro Deficits present, Spinal Tenderness present, Altered Mental status, Intoxication, or Distracting Injury).
- An AEMT and/or EMT-P may remove if placed by BLS crew and it does not meet indicators.

Continuous Positive Airway Pressure Device (CPAP) - Adult (EMT, AEMT and EMT-P)

- Start at lowest setting and increase slowly until patient experiences relief or until a maximum of 15 cm H_2O is reached.

External Jugular Vein Access (AEMT and EMT-P)

- Not indicated for patients eight (8) years of age and younger.
- Patient condition requires IV access and other peripheral venous access attempts are unsuccessful.

Intraosseous Insertion (AEMT pediatric patients only and EMT-P)

- EMT-Ps may administer Lidocaine slowly per ICEMA Reference #7040 - Medication - Standard Orders, to control infusion pain.
- Approved insertion sites:
  - Eight (8) years of age or younger (LALS and ALS):
    - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.

- Nine (9) years of age and older (ALS only):
  - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.
  - Distal Tibia - Lower end of tibia, 2 cm above the medial malleolus.
  - Humeral Head (EZ IO only).
  - Anterior distal femur, 2 cm above the patella - Base hospital contact only.

- Leave site visible and monitor for extravasation.

King Airway Device (Perilaryngeal) - Adult (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - Patients 15 years or older.
  - Anyone over four (4) feet in height.
- Additional considerations:
  - Medications may **not** be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

King Airway Device (Perilaryngeal) - Pediatric (less than 15 years of age) (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - No gag reflex.
  - Pediatric patients meeting the following criteria:
    - 35 - 45 inches or 12 - 25 kg: size 2
    - 41 - 51 inches or 25 - 35 kg: size 2.5

- Additional Considerations:
  - Medications may NOT be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

Nasogastric/Orogastric Tube (EMT-P)

- Use viscous Lidocaine gel per ICEMA Reference #7040 - Medication - Standard Orders, for conscious patients.
- Required for all full arrest patients.

Nasotracheal Intubation (EMT-P)

- Absolute contraindication: Apnea.
- Base hospital contact required: Facial trauma, anticoagulant therapy, airway burns, failed CPAP.
- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for suspected head/brain injury.
- Administer Phenylephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to place ET after a maximum of three (3) nasotracheal intubation attempts or if unable to adequately ventilate patient via BVM.

Needle Cricothyrotomy (EMT-P)

- Absolute contraindication: Transection of the distal trachea.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to ventilate adequately and transport immediately to the closest hospital for airway management.

Needle Thoracostomy (EMT-P)

- In blunt chest trauma consider bilateral tension pneumothorax if pulse oximetry (SpO_2) reading remains low with a patent airway or with poor respiratory compliance.

Oral Endotracheal Intubation - Adult (EMT-P)

- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for head injury.

- Monitor end-tidal CO_2 and wave form capnography.

- Monitor pulse oximetry.

- If unable to place ET after a maximum of three (3) intubation attempts (an attempt is considered made when tube passes the gum line) and, if all procedures to establish an adequate airway fail, consider Needle Cricothyrotomy.

- Document verification of tube placement (auscultation, visualization, capnography)

Synchronized Cardioversion (EMT-P)

- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety.

- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.

- If rhythm deteriorates to v-fib, turn off the sync button and defibrillate.

- Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines. Procedure may be repeated at 200, 300 and 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.

- In Radio Communication Failure or with base hospital order, repeated cardioversion attempts at 360 joules or clinically equivalent biphasic energy level per manufacturer's guidelines may be attempted.

Transcutaneous Cardiac Pacing (EMT-P)

- Start at a rate of sixty (60) and adjust output to the lowest setting to maintain capture. Assess peripheral pulses and confirm correlation with paced rhythm.

- Reassess peripheral pulses. Adjust output to compensate for loss of capture.
- Increase rate **(not to exceed 100)** to maintain adequate tissue perfusion.
- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety
- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.
- Contact the base hospital if rhythm persists or for continued signs of inadequate tissue perfusion.

Vagal Maneuvers (EMT-P)

- Relative contraindications for patients with hypertension, suspected STEMI, or suspected head/brain injury.
- Reassess cardiac and hemodynamic status. Document rhythm before, during and after procedure.
- If rhythm does not covert within ten (10) seconds, follow ICEMA Reference #11050 -Tachycardias - Adult.

TACHYCARDIAS - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

Narrow Complex Supraventricular Tachycardia (SVT)

- Initiate NS bolus of 300 ml IV.
- Valsalva/vagal maneuvers.
- Adenosine per ICEMA Reference #7040 - Medication - Standard Orders.
- Synchronized cardioversion, refer to ICEMA Reference #10190 - Procedure - Standard Orders.
- Contact base hospital.

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

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

Atrial Fib/Flutter

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

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	Procedure - Standard Orders

END OF LIFE CARE AND DECISIONS

I. PURPOSE

To establish criteria that recognizes and accommodates a patient's designated end of life directives to limit prehospital treatment by Emergency Medical Service (EMS) field personnel in the prehospital setting, long-term care facilities, during transport between facilities and/or in the patient's home.

II. 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
- Cardiotonic drugs, e.g., Epinephrine, Atropine or other medications intended to treat a non-perfusing rhythm

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) approved medallion providers for California. 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.**

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 family with planning that reflect the patient's end of life wishes. It is also intended to assist physicians, nurses, healthcare 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
- POLST form
- 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.

Forms related to patient's end of life instructions that EMS field personnel may encounter include:

- Statewide EMSA/California Medical Association (CMA) Prehospital DNR form.
- POLST form.
- 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 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 healthcare decisions.
  - Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
  - All signatures 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 by 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 authorized healthcare 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 field personnel 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 electronic patient care record (ePCR) 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.

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 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 report, 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 ePCR 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 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.

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.

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

RESPONSIVE

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

UNRESPONSIVE

- Position patient supine (for suspected trauma maintain in-line axial stabilization). Place under-shoulder support to achieve neutral cervical spinal position if indicated.
- Begin CPR, starting with thirty (30) compressions.

- Open airway using the head tilt-chin lift method (for suspected trauma, use jaw thrust). Remove object if visible.

- If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise or unable to ventilate, continue cycles of thirty (30) compressions to two (2) ventilations until obstruction is relieved or able to ventilate.

- If apneic and able to ventilate, provide one (1) breath every three (3) to five (5) seconds. Confirm that pulses are present and reassess every two (2) minutes.

III. LIMITED ALS (LALS) INTERVENTIONS

- If apneic and able to ventilate, consider King Airway placement per ICEMA Reference #10190 - Procedure - Standard Orders.

- If obstruction persists continue with compressions until obstruction is relieved or arrival at hospital.

- Transport to closest receiving hospital for airway management.

IV. ALS INTERVENTIONS

- If obstruction persists and unable to ventilate, attempt to visualize and remove visible foreign body with Magill forceps and attempt to ventilate.

- If obstruction persists, consider Needle Cricothyrotomy per ICEMA Reference #10190 - Procedure - Standard Orders.

V. REFERENCE

Number	**Name**
10190	Procedure - Standard Orders

CARDIAC ARREST - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting. Consider the potential causes of arrest for age.

II. BLS INTERVENTIONS

- Assess patient, maintain appropriate airway; begin CPR according to current AHA Guidelines.
  - Ventilate at rate of 12 to 20 per minute. Ventilatory rate will decrease as patient age increases. Ventilatory volumes shall be the minimum necessary to cause chest rise.
  - Compression rate shall be a minimum of 100 per minute.
- If patient one (1) year of age or older, utilize AED.

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- Follow the instructions from the AED to determine if shock is advised.
- Obtain IO/IV access (IO is preferred for under nine (9) years of age).
- Establish advanced airway with minimal interruption to CPR, when resources are available.
- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
  - 1 day to 8 years: 20 ml/kg NS
  - 9 to 14 years: 300 ml NS

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

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine the cardiac rhythm and defibrillate at 2 j/kg (or manufacturer's recommended equivalent) if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IO/IV access (IO is preferred).
- Insert NG/OG tube after advanced airway is established or if not placed with BLS airway.
- Continue CPR with compressions at a minimum of 100 /min without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.
- Utilize continuous quantitative waveform capnography, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status.

<u>Ventricular Fibrillation/Pulseless Ventricular Tachycardia</u>

- Initial defibrillation is administered at 2 j/kg (or manufacturer's recommended equivalent). Second defibrillation is administered at 4 j/kg. Third and subsequent defibrillation attempts should be administered at 10 j/kg not to exceed the adult dose.

- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.

- Administer Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each defibrillation unless capnography indicates possible ROSC.

- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as indicated above.

- After two (2) cycles of CPR, consider administering Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders, may repeat.

- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base hospital.

Pulseless Electrical Activity/Asystole

- Assess for reversible causes and initiate treatment.

- Continue CPR with evaluation of rhythm every two (2) minutes.

- Administer initial fluid bolus of 20 ml/kg NS for all ages, may repeat at:

  - 1 day to 8 years: 20 ml/kg NS

  - 9 to 14 years: 300 ml NS

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

Treatment Modalities for Managing Pediatric Cardiac Arrest Patient

Whenever possible, provide family members with the option of being present during the resuscitation of an infant or a child. For any termination of efforts, base hospital contact is required.

- Insert NG/OG tube to relieve gastric distention if the patient has an advanced or BLS airway per ICEMA Reference #10190 - Procedure - Standard Orders.

- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.

  - 1 day to 8 years: 20 ml/kg NS

  - 9 to 14 years: 300 ml NS

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

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

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

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	Procedure - Standard Orders

SEIZURE - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

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

IV. ALS INTERVENTIONS

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

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

BURNS - PEDIATRIC
(Less Than 15 Years of Age)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. <u>Manage Special Considerations</u>

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

- **Eye Involvement**: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Airway Stabilization (as indicated). Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- IV/IO Access (warm IV fluids when available).
  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.
  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
  - < 5 years of age: IV NS 150 ml/hour
  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

- Refer to Section V - Burn Classifications below.

A. <u>Manage Special Considerations</u>

- **Respiratory Distress**:
  - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
  - Administer humidified oxygen, if available.

- **Deteriorating Vital Signs**: Transport to the closest receiving hospital. Contact base hospital.

- **Pulseness and Apneic**: Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.

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

- **Precautions and Comments**:

  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.

  - Do not apply ice or ice water directly to skin surfaces as additional injury will result.

  - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

IV. ALS INTERVENTIONS

- Establish advanced airway as clinically indicated.

  - Airway Stabilization: Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.

  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

  - < 5 years of age: IV NS 150 ml/hour

  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Treat pain as indicated.

  - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.

- Document vital signs every five (5) minutes while medicating for pain, and reassess the patient.

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
  - Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

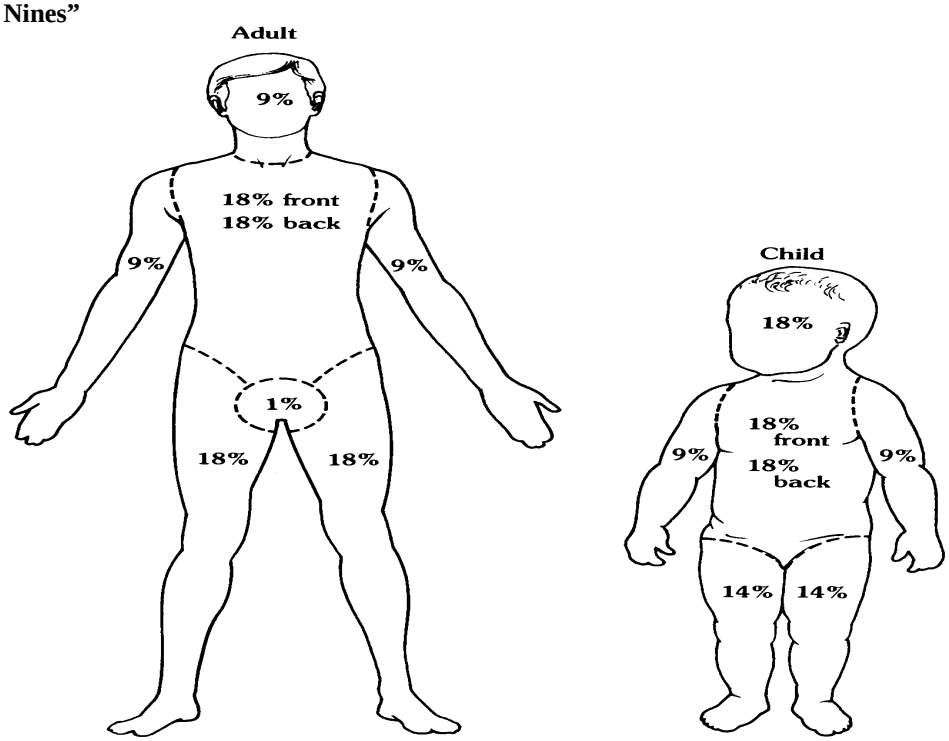
A. <u>Manage Special Considerations</u>

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

V. BURN CLASSIFICATIONS

PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
MINOR - PEDIATRIC • < 5% TBSA • < 2% Full Thickness	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MODERATE - PEDIATRIC • 5 - 10% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MAJOR - PEDIATRIC • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints	**CLOSEST MOST APPROPRIATE BURN CENTER** In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)

"Rule of Nines"



VI. REFERENCES

Number	Name
7040	Medication - Standard Orders
8130	Destination Policy
12010	Determination of Death on Scene

TRAUMA - ADULT
(15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O_2 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. <u>Manage Special Considerations</u>

- **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 axial spinal 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 axial spinal immobilization.

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.

- **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 2nd IV access.

  - *Stable*: BP>90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

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

  - *Stable*: IV NS TKO

  Penetrating Trauma:

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

  - *Stable*: IV NS TKO

  Isolated Closed Head Injury:

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

  - *Stable*: IV NS TKO

- Transport to appropriate hospital.

A. <u>Manage Special Considerations</u>

- **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 axial spinal 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.

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.

- **Fractures**:

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

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

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

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

  - ➢ Apply AED and follow the voice prompts.

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

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

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

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

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- **Precautions and Comments**:

  - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.

  - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

  - If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.

  - **Unsafe scene may warrant transport despite low potential for survival.**

  - Whenever possible, consider minimal disturbance of a potential crime scene.

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

IV. ALS INTERVENTIONS

- Advanced Airway (as indicated):

  - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #8120 - Continuation of Care.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* BP <90mmHG and/or signs of inadequate perfusion, start 2nd IV access.

  - *Stable*: BP >90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

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

  - *Stable*: IV NS TKO

Penetrating Trauma:

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

Isolated Closed Head Injury:

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

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

A. <u>Manage Special Considerations</u>

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

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

  - Consider maintaining spinal alignment on the gurney, or using axial spinal 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.

  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.

- **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

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

01A & F-1612 SCANTRON FORM INSTRUCTIONS

PURPOSE

To help field providers in the proper, complete, and accurate documentation of prehospital care using ICEMA Run Report Forms. The 01A Narrative Form serves as the regional version of the EMT-P's Patient Care Record (PCR) as required in Title 22, Division 9 of the California Administrative Code (EMT-P regulations). The computer readable F-1612 data form is a data collection instrument designed to provide all core data for quality assurance, statewide and regional EMS system evaluation. Questions regarding completion of these forms, or to arrange a class teaching the use of these forms, contact ICEMA at 909-388-5820.

MARKING THE FORM

The 01A Form is a 4-part form printed on carbon less, pressure sensitive (NCR) paper. EMS personnel completing the form must make marks with a standard ink pen heavily enough to leave a legible impression on all copies. We recommend placing the form on a clipboard or other hard surface while you are making marks. When completing the reverse sides of the form, write on each form separately as the NCR paper will cause marks on the front of the O1A form.

DISPOSITION OF COPIES

WHITE:

The EMS service provider agency will keep the ***white*** (original/first part) copy of the 01A form.

GREEN:

The ***green*** copy of the 01A form becomes part of the patients' medical record for the receiving hospital. It is to accompany the patient to the receiving hospital for inclusion in the patient's medical record. When a transporting service provider (ambulance) arrives and prepares to transport, the first service provider agency will give their green medical copy to the transporting agency, even if the 01A form has not been completed. The 01A form may then be completed after the patient has left the scene, noting that fact in the comments. Do NOT have the patient wait for transporting while you are completing a form.

YELLOW:

The EMS service provider agency will send ***all designated yellow*** copies of the 01A form to ICEMA each month. ***Designated copies*** **are 1) patients under 18 years of age, 2) expanded scope skills, 3) expanded scope medications, and 4) ET attempts**. ICEMA

DELETE

reserves the discretion to request additional 01A forms from each agency. The Agency EMS Coordinator, and/or the assigned Base Hospital PLN must review each 01A with expanded scope skills and/or medications before sending them to ICEMA.

PINK:

The ***pink*** copy of the 01A form serves as a billing or extra copy for the EMS service provider agency (the field provider's employer). This copy may be used for educational purposes or prehospital research that is being conducted. It may be sent to the base hospital or other requesting party as requested. When using this copy for outside agencies, black out the patient's name and any personal identifying information.

WHEN TO COMPLETE A FORM

For every patient contact, a 01A form is required, including interfacility transfers. Each patient on scene will have a separate form completed. Each ALS provider, who makes patient contact, must complete a 01A form for that patient. Separate crews from the same provider that give care to the same patient, must complete a separate 01A form for the care they gave. Record items that reflect only those services provided by the person(s) completing the form. When one provider takes over care from another, record the ICEMA number from the 01A form completed by the transferring care provider in the space titled "Other ICEMA #."

EMERGENCY CALLS

EMT-P'S must completely fill out a 01A form for every emergency call where patient contact is made.

Exceptions are as follows:

1. Weight may be left blank if not used for treatment;
2. Mechanisms of injury should be blank for non trauma patients;
3. Zones may be blank if not applicable to the local area;
4. EKG rhythm should be blank if no EKG is done.

INTERFACILITY TRANSFERS

For reporting purposes, an "interfacility transfer" is a call on which a patient is transported from a hospital to another health care facility or other location. This includes calls on which they took a patient from a hospital to a nursing home (or vice versa); from a hospital to the patient's home; or from a hospital to another hospital. **ALS interfacility transfers (paramedic on the unit) require both a 01A Narrative form and an F-1612 data form.**

The following 01A Form items are to be completed for all ALS interfacility transfers:

DELETE

1. patient name, home address and zip code
2. patient age and sex
3. chief complaint
4. blood pressure, respiration rates, respiratory efforts, capillary refill, eye opening
5. verbal response, motor response
6. head-to-toe physical assessment
7. care rendered (if any), response to treatment rendered and time administered
8. incident number
9. run dates
10. unit number
11. location (address of facility where patient is picked up)
12. times call for transport received
13. time dispatched (en route)
14. time of arrival at transferring hospitals
15. time departed a transferring hospital
16. time arrived at destination facility
17. receiving hospitals (or facility) code (for location to which patient transferred)
18. attendant signatures(s)
19. signature of person receiving the patient at the destination facility

CANCELED CALLS

A call is considered "canceled en route" when the dispatcher notifies the unit that they have canceled before the unit arrives on scene; that is, **before they make patient contact**. A **01A FORM IS NOT REQUIRED for a call that is canceled enroute**. We recommend that provider agencies use a form for data collection (for example, a dispatch report form) that contains, at a minimum, the following information:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. call outcomes ("canceled en route")
8. attendant certification number(s)
9. provider

DRY RUNS

For reporting purposes, a "dry run" is a call on which **no patient contact is made at the scene. A 01A FORM IS NOT REQUIRED FOR THIS TYPE OF RUN.** However, if patient contact is made, and the patient refuses treatment or transport, an O1A form is

DELETE

required. For dry runs with no patient contact, provider agencies may use an alternative method of data collection of their choice that contains, at a minimum, the following data:

1. incident number
2. run dates
3. incident cities
4. time call received
5. time en route to the scene
6. run code to the scene
7. Call outcomes ("dry run-no pt.")
8. attendant certification number(s)
9. provider and unit number

DETAILS FOR COMPLETING THE PCR 01A NARRATIVE FORM

CANCELED ~ AMA ~ TRANSPORT ~ AIR

Mark the appropriate box for the run.

ICEMA NUMBER

The preprinted ICEMA number is located at the upper left corner of the 01A Narrative form. Mark this number on the corresponding F-1612 data form in the spaces provided for "ICEMA #" (central bottom portions of the data form).

PRIM. INC. #

Obtain this number from the dispatcher, normally after completion of the call. This is the incident (dispatch) number of the provider agency that sends the unit to the scene. Write the number in the space shown.

OTHER PROVIDER

Document the transporting agency's abbreviated name and the unit number of the vehicle when you transfer patient care to another provider for transport.

DATE

Write the date on which the provider agency received the call. Use a six-digit number. For example, enter 06/01/02 for June 1, 2002.

UNIT

DELETE

This space is for the unit number (as assigned by the provider agency) of the vehicle that responded to the incident.

LOCATION OF CALL

Write the location of the incident as supplied by the agency dispatcher. Record the street number and street name when available. If they do not provide these items, record the cross streets and nearest city or community. Do not write "home" or "same."

CITY

Write the name of the city where the incident occurred. Use this to decide the city code entered on the F-1612 data form.

ZONE

Use this space to record the State Fire Marshall's fire demand zone number or the zone within a city designated by an EMS provider agency. ICEMA does not require the zone, use at the discretion of the provider agency.

NAME ~ ADDRESS ~ CITY ~ STATE ~ ZIP

Write in the patient's full name (first name, middle initial if any, and last name) on the line provided near the top of the form. Write the patient's street address, mailing address if different, the city where the patient resides, two-letter postal abbreviations for the state, and zip code on the second blank line. While on scene, and the patient is in a life-threatening situation or unable to provide an address, obtain the information from hospital personnel at the receiving hospital.

PHONE

Record telephone number to include area code.

SOCIAL SECURITY NUMBER

Enter nine-digit number.

AGE

After identifying the patient at the scene and inquiring about his or her age, record the age in years in the space shown.

DOB

DELETE

Record the patient's date of birth in 6-digit format, for example, 01/01/02.

M/F

Record the patient's sex. Check the box before "M" for male, or "F" for female.

APPROX. WEIGHT

For all pediatric patients, write the patient's weight, in kilograms, in the space provided. For adults, record the weight only if necessary to treatment (for example, if drug dosage for patient condition depends upon body weight).

APPROX. HEIGHT

For all pediatric patients, record the patient's height, in feet and inches, in the space provided. For adults, record height only if weight is also necessary.

PT __ OF __

Enter assigned patient number out of total number of patients transported.

CARE PRIOR TO ARRIVAL

Check the appropriate box for the type of emergency care given prior to your unit's arrival.

1. None: No prior care.
2. CPR: If started prior to your arrival on scene
3. Other BLS: Any procedure listed in the Care Rendered-left column on the F-1612 data form.
4. ALS: Any procedure listed in the Care Rendered-right column on the F-1612 data form.

PRIOR CARE GIVER

Mark the appropriate box to show the type of agency/individual providing care prior to your unit's arrival on the scene.

1. CITZ.: a citizen, bystander, or relative provided care.
2. None: no prior caregiver.
3. Medical: physician, nurse, first responders, ski patrol, or other trained medical person on a scene provided prior care.
4. FD/BLS: a BLS unit provided prior care.
5. Law Enforce: police, sheriff, or other law enforcement personnel provided care.

DELETE

6. FD/ALS: a non-transporting ALS unit provided prior care.
7. ALS Amb: ALS ambulance personnel provided prior care.

RECEIVED

Time call is first received by EMS Provider Agency. This time may be received from the dispatcher after completion of the call. Write the time, in hours and minutes, using military time (a 24-hour clock) in the box provided. Valid times range from zero (midnight) to 2359 (11:59 p.m.). **Do NOT use 2400. Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

EN ROUTE

Time that the response unit begins physical motion; i.e. wheels begin to turn.

ARRIVE

Time the EMS unit stops physical motion at scene on staging area; i.e. wheels stop turning. (Last place that the unit vehicle stops prior to assessing the patient.)

PT. CONTACT

Time response personnel establish direct contact with patient.

DEPART

Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. If you transport a patient, record DEPART as the time the ambulance leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARRIV. DEST/END CALL

Time when patient arrives at destination or transfer point, i.e. wheels stop turning. Leave blank if your unit is not transporting the patient. Note**: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.**

AVAILABLE

Record the time that the unit is back in service and available for another call, whether they transported the patient or not.

DELETE

DELETE

CODE EN ROUTE

Circle the number that corresponds to the definitions below by which the unit responded to the incident:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens

CODE DEPART

Circle the number that corresponds to the mode of transportation the ambulance utilized enroute to the hospital (1, 2, or 3, as described above). If transportation does not occur, leave this item blank.

ODOMETER

Use this section as directed by your employer. ICEMA does not require odometer readings.

FAC. CONTACTED

Write an abbreviation for the base hospital contacted on this call. If the unit never attempted to make voice contact with the Base Hospital, write "none." If the Base Hospital was successfully contacted, mark the type of instrument/frequency utilized:

1. BH: Base Hospital
2. VHF: EMS/HEAR radio
3. UHF: Bio-com
4. Phone: Land line telephones
5. CELL: Cell phone
6. 800Mhz: San Bernardino County system
7. None: In Radio Communication failure record the BH name

CONTACT TIME

Record the time contact was initiated with the base hospital.

RECEIVING HOSPITAL

Record the name or appropriate abbreviation for the hospital where the patient was transported.

Mark the ONE category that best describes the reason for selection of the receiving hospital:

Pt. Request: patient or patient's physician requested this facility
Diversion: the original receiving hospital selected was on diversion for this type of call
Trauma: transported to this facility because they require a trauma center
RCF: radio communication failure
Peds trauma: they require a pediatric trauma center
Reroute: the receiving hospital destination changed while the unit was en route from scene. E.g., a change in patient condition required selection of a different facility). Not to include change in the destination based upon hospital status (see "diversion")
Closest: the hospital is selected because it is closest to the scene
Other: a reason other than those listed above in selecting the receiving hospital

CHIEF COMPLAINT

Use the blank space under this heading to describe details of the patient's problem. Describe the location of injury; (head, face, neck, chest, abdomen, rt. or lt. arm or leg, rt. or lt. hand or foot), or sites of pain; the type of injury or pain (e.g., fracture, laceration, etc.), and other medically relevant signs and symptoms (e.g., estimated blood loss). Include drug or alcohol use here.

MECHANISM OF INJURY

For all trauma patients, record the reported cause of injury. Categories include motor vehicle accidents (MVA), motorcycle collisions (MCA), GSW, stabbing etc. For falls, specify if more than 20 feet. Show whether injury is blunt or penetrating. If undeterminable, write "unknown." Circle “Y”-yes or “N”-no to the following questions; did the patient wear a helmet, a seat belt, have a loss of consciousness (LOC), and was an airbag inflated?

MED. HISTORY

Use this space to record the patient’s medical history. History may include cardiac, respiratory, liver, kidney, or other known disease, any recent and/or related illnesses, medical conditions, hospitalizations, history of trauma, or medical treatments. Also, record the time of injury or time of onset of symptoms as stated by the patient. Check appropriate predesignated diagnosis if one applies to the patient.

MEDICATION

Write the names of all prescription or over-the-counter medications the patient is currently taking. Abbreviate as necessary. If they do not know the specific name of the drug, record the class of drug or the action it takes (e.g., insulin, diuretic, an antidepressant,

DELETE

antihistamine, etc.). Include dose and frequency if it is taken daily (e.g., Bid, T.i.d., QD). Bring any medication not quickly identifiable to the hospital with the patient.

ALLERGIES

Mark the box 'NKA' for no known allergies. Otherwise, record the names of any medications to which the patient has had an allergic reaction. Also record any other allergies either related to the current problem (for example, the mechanism of injury is "bite/sting" and the patient is allergic to bee stings), or environmental allergies (for example Latex allergies).

BLOOD PRESSURE

Record the time (use a 24-hour clock) and initial blood pressure reading as systolic/diastolic. Note if auscultation or palpation was used to obtain B/P. Record blood pressure readings as required by protocol. If you require additional space, use the Narrative section.

PULSE

Record the rate and quality of the pulse (e.g., thready, bounding, irregular). Use appropriate abbreviations (e.g., 70 norm., 60 irreg.). Record repeated pulse rate and quality as required by protocol. Use the Narrative section for additional space, if required.

RESPIRATION

Record the rate, number of respiration's per minute/quality of respiration's (e.g., clear, wheezes, rales, unequal, or absent). Record repeated respiratory rate and quality as required by protocol. Describe lung sounds as auscultated with a stethoscope. Use the Narrative section for additional space, if required.

PULSE OX

Give numeric value as a percentile and whether it was taken on room air or with supplemental oxygen.

SKIN COLOR

Mark the category that most closely matches the patient's skin color upon initial assessment: normal, pale/ashen, cyanotic, or flushed. Check box "A" for first time observed and box "B" where a vital sign is repeated record time for "A" and time "B" in line provided.

DELETE

DELETE

MOISTURE

Mark how much skin moisture noted on initial assessment: normal, dry, moist, or profusely diaphoretic.

SKIN TEMP

Mark the patient's skin temperature as noted on initial assessment: hot, warm, cool, or cold.

PUPILS - LT (LEFT) RT (RIGHT)

Mark the boxes that best describes the pupillary response or status upon initial assessment of the patient. Separate columns are provided for description of pupillary response in left and right eyes.

RESPIRATORY EFF.

Record the patient's visible respiratory effort (chest wall movement), mark the box next to the category that better describes the present condition for this patient--normal, or abnormal (shallow/retractive/none).

1. Normal: easy, unlabored, deep respirations.
2. Shallow: diminished volume of respirations.
3. Retractive: this involves the use of the accessory and/or abdominal muscles for breathing.
4. None: mark if patient has no apparent respirations.

If no box is marked, it will be assumed that no assessment was done.

CAPILLARY REFILL

Mark the box next to the category that best describes the patient's capillary refill upon assessment.

1. Immediate: return of color in two seconds or less.
2. Delayed: color does not return in less than two seconds
3. None: no return of color.

EYE OPENING

Note the patient's initial ability to open his/her eye(s). Mark the box next to the appropriate category.

1. Spontaneous: patients' eyes open without stimulation; patient can close eyes upon

request.
2. To voice: eyes open when the patient's name is spoken or shouted.
3. To pain: eyes open in response to a standard pain stimulus.
4. None: eyes do not open despite a stimulus.

VERBAL RESPONSE

Mark the box next to the category that describes this patient's initial best verbal response.

1. Oriented: correctly responds when asked name, place, date, and history of an event.
2. Confused: incorrectly responds to questions, but can produce phrases of more than two
3. Inappropriate: able to produce only an intact word or two in response to physical stimulation.
4. Incomprehensible: able to produce sounds (mumbling or groaning), but no words.
5. None: no verbal response to any stimulation.

MOTOR RESPONSE

Mark the box next to the patient's initial best motor response.

1. Obedient: Pt. ability to comprehend, physically execute a spoken or written instruction.
2. Purposeful: patient responds to a standard pain stimulus.
3. Withdrawal: no verbal response; the elbows flex rapidly with no muscle stiffness.
4. Flexion: no verbal response; the elbows flex slowly and muscle is stiff.
5. Extension: no verbal response; arms and/or legs out; muscles are stiff.
6. None: no verbal or motor response.

PULSE

Mark the box next to the appropriate area (Femoral, Radial, Carotid) as present or absent.

GCS

Enter the GCS (Glasgow Coma Scale) and include in report to base hospital.

PT PHYSICIAN

Enter name of patients' physicians, if known.

TEMP

Enter patients' body temperature and location taken (oral, tympanic).

DELETE

DELETE

BLOOD GLUCOSE D50/D25

Enter blood glucose numeric value before D50/D25 was given and enter a secondary numeric value for the repeat blood glucose after the administration of D50/D25.

END-TIDAL Co2 DETECTED

If the patient is intubated, note detection of Co2 after placement, before the patient is moved and after moving patient.

SECONDARY SURVEY

Mark the box for the appropriate category in each section of the "**neuro/head**" survey.

WNL: within normal limits.
N/A: not applicable.
ABN: abnormal.

In the comments section next to "**neck**", mark box if no JVD (jugular venous distention); next to "**chest**", mark if negative barrel hoop; next to "**abdomen**", mark if soft and/supple; next to "**back-spine**", mark if full spinal immobilization was instituted (this constitutes rigid collar, head/chin straps, head bed, long board and straps); next to "**pelvis**", mark box if negative or no instability noticed; next to "**extreme**", mark box if no distal edema and if the patient has full range of motion.

NARCOTIC GIVEN ~ NARCOTIC WASTED

Enter the amount of the narcotic given to patient. Enter the amount, date, time, and location where narcotic was wasted. The EMT-P and the Nurse who witnessed the waste of the narcotic must sign in the appropriate area.

EKG - DEFIB RHYTHM

When an EMS field provider places a patient on the monitor, this area must be completed. Do not record a rhythm obtained by another unit. Record the initial and any subsequent rhythms in the spaces provided. Enter energy level in joules if patient is cardioverted or defibrillated, and rhythm following procedure. If TCP is utilized note capture, rate and amperes used. If additional space is needed, continue in the Narrative/Assessment section.

CARE RENDERED

Record the time that any medication or procedure was ordered or initiated by the EMT/Paramedic, using the 24-hour clock format. Identify medications and procedures

prior to Base Hospital contact with the abbreviation "PTC" immediately following the time. **Be sure to include all types of treatment in this section. Record only those treatments provided by attendants signing this form.** Record the time when each procedure was initiated. Include RT/Size-route and size of appliance used, dose and response to treatment in sections provided. Record the complete name of all drugs administered, with the time ordered, route, dose, and time administered. Use abbreviations as necessary. If the Base Hospital ordered, medications or procedures but where not completed please note that fact in this section

PQRST

Record in the PQRST box as applicable.

"P" Provoke-what provoked pain?
"Q" Quality of pain-sharp/dull?
"R" Radiate-where does the pain radiate?
"S" Severity-have the patient rate on a 1-10 scale how severe they feel the pain is, one being the least pain they've experienced and 10 being the worst.
"T" Time-how long have they had the pain?

NARRATIVE/ASSESSMENT

Use this section for details concerning the patient. Include exceptions and unusual conditions or circumstances. Record the type of care administered prior to arrival of this unit. Overall change (or no change) in patient condition. Do not record personal opinions. Note pertinent negatives in physical assessment and response or change after care rendered. Use **ICEMA Supplemental Patient Report** form if more space is needed.

3 TEAM MEMBER SIGNATURE AREAS

This area is for the name and Accreditation/Certification number of the team members. Mark the appropriate box for each team member.

1. Patient Attendant: The team member responsible for patient care.
2. Radio Attendant: The team member who made contact with the Base Hospital.
3. Completed form: The team member who actually completed the O1A form.
4. Other: Mark this box if there is a third member (trainee or ride out).

FORM NOT COMPLETED ON SCENE

Mark this box when the O1A form is not completed on scene.

DELETE

PT RECEIVED BY

The physician or nurse taking responsibility for the patient must sign this area upon arrival at the receiving hospital or facility. When an air ambulance takes a patient from a ground ambulance for further transport, the person on the air transport crew will sign here. They now assume responsibility for patient care. The ground ambulance gives the second green copy of the form to the person whose signature appears in this area.

REVERSE SIDES OF FORM

The reverse sides of the original and three copies of the 01A Narrative form contain additional printed information. When filling out the reverse sides remember to write only on the form you are using.

BACK OF FIRST (WHITE) COPY

BILLING INFORMATION

This is the provider's copy. Complete this section as directed by your employer. ICEMA does not require completion of billing information.

MEDICAL/LIABILITY RELEASE FORM

If the patient refuses treatment, have the patient complete the "Medical Liability Release Form" on the back of the first copy (white) of the 01A Narrative form. If the patient is a minor, also have the parent or guardians sign the release. Sign the release in the area for Witness 1, and obtain the signature of a second witness. If Base Hospital contact was made, mark the box next to "Yes" on the bottom of the release; otherwise, mark "No". Document in the Narrative all pertinent information regarding the incident.

PHYSICIAN'S RESPONSIBILITY

If a physician on scene states a desire to take charge of the patient, he or she must show a current California Medical Physician's License. The doctor must read the "Physician's Responsibility" statement on the back of the first copy (white) of the 01A form and must sign the form, including his or her license number and expiration date. Make Base Hospital contact and state that a physician is on scene requesting to take medical control of the patient. **If the Base Hospital physician agrees to relinquish control** you may perform any procedure or give any medication approved for use in the ICEMA region under the direction of the physician on scene. This physician must accompany the patient to the receiving facility in the ambulance. The field provider must complete the 01A form as usual.

DELETE

BACK OF SECOND (GREEN) COPY

THROMBOLYTIC ASSESSMENT

This checklist should be completed while enroute on all chest pain patients. This information should be conveyed to the Base Hospital as soon as possible.

BASE HOSPITAL/RECEIVING FACILITY

These codes are to be used to identify the Base Hospital/Receiving Facility

RULE OF NINES CHART

This chart is included to assist the provider in determining burn percentages for the adult and pediatric patient.

APGAR SCORING

This chart is available for use in assessment of the newborn infant.

STANDARDIZED ABBREVIATIONS

These should be used consistently throughout the completion of the form. If an abbreviation is questionable, completely spell out the word so it is clear and concise to any individual reading the form.

BACK OF THIRD (YELLOW) COPY

This completed form must be given to the Base Hospital PLN; if patient is transported there, OR given to your QI/EMS Coordinator if patient transported to another facility. Complete for evaluation of the advanced skills: Adult Endotracheal Intubation, Pediatric Endotracheal Intubation, Nasotracheal Intubation, Percutaneous Needle Cricothyrotomy, Intraosseous Infusion and Transcutaneous Cardiac Pacing.

1. In space provided **record the patient's name** as written on the original 01A form.
2. Record the ICEMA run report number in space provided from the front of the 01A form.
3. Check all the procedures utilized in the boxes provided.

INTUBATION

Check the box provided for an adult or pediatric patient. Then mark the route used, (nasal or oral). Enter size of ET tube, number of attempts made and yes or no to if the procedure was successful.

DELETE

DELETE

NEEDLE CRICOTHYROTOMY

Enter the size of the needle, or name of the approved device, number of attempts and if the procedure was successful.

INTRAOSSEOUS INFUSION

State the size of the IO catheter, number of attempts and if the procedure was successful.

PLACEMENT VERIFIED

Document how you verified proper placement of device/procedure.

TRANSCUTANEOUS CARDIAC PACING

Document if the transcutaneous pacer captured the rhythm:

1. HR: The rate at which the pacemaker captured.
2. AMP: The amplitude needed to capture.
3. Palpable pulse rate: The palpated HR in beats per minute.
4. B/P: Blood pressure after pacing achieved.
5. Atropine given: Yes or No.

PULSE OXIMETRY

Record numeric value in a percentage of O2 present before treatment and after treatment.

END TIDAL CO2

Record if detected-yes or no, and percentage detected.

IF THE PROCEDURE YOU USED WAS SUCCESSFUL

Explain in the narrative the patient's response to treatment.

IF THE PROCEDURE YOU USED WAS UNSUCCESSFUL

Explain in the narrative what you felt inhibited the procedure from being successful (e.g., irreg. Anatomical structure, broken equipment, incorrect placement, etc.).

FIELD ASSESSMENT/TREATMENT INDICATORS

Document all the patient indicators for the procedure performed.

PROCEDURE PERFORMED

Document how procedure was performed: prior to contact, in radio communication failure (RCF), or upon base hospital order.

OTHER DOCUMENTATION

Document the name of the Receiving Facility, and/or the Base Hospital. Have receiving hospital physician sign the form in the space provided. The paramedic who completed the skill and the evaluation form signs the form in the space provided. The paramedic must give this form to the PLN at the contacted Base Hospital for review if the patient was transported to that facility or to their QI/EMS Coordinator if patient was transported to another facility.

PLN DOCUMENTATION

This area needs to be completed by either the PLN or QI/EMS Coordinator and sent to the ICEMA ALS Coordinator with a photocopy of both sides of the 01A form on a monthly basis.

BACK OF FOURTH (PINK) COPY

MULTIPLE PATIENT TRIAGE FORM

This area is provided to assist with multiple casualty incidents. This form is to help the team members with rapid patient assessment and organization. **Each patient requires a separate 01A Form and F-1612 data form.**

PATIENT TRANSPORTATION RECORD/MCI WORK SHEET

This is a work sheet provided to assist the paramedic with keeping track of where multiple patients are transported during a MCI. For each patient, enter:

1. name of the transporting agency
2. patient's triage tag number
3. approximate age and sex (M or F)
4. patient's triage priority status; "**I**" for immediate, "**D**" for delayed, or "**M**" for minor

Enter a brief description for chief complaint, and ETA in minutes from scene departure to arrival at receiving hospital. Record "Off Scene Time" as the time the transporting unit leaves the scene**. Following initial triage, complete a full set of Run Report Forms for each patient**. Information recorded on the multiple patient triage form can transfer to the front of the individual patient's 01A form.

DELETE

INSTRUCTIONS FOR COMPLETING THE PCR F-1612 DATA COLLECTION FORM

MARKING THE FORM

The F-1612 data form is to be completed separately from the 01A form. Complete all marks on this form within the boxes or "bubbles" in ink, (any dark color except red) or a black pencil. Mark only designated boxes. No other marks or comment should appear. For optimal scanning, **do not fold, staple, paper clip, or bend this form.** The scanner will read any other writing, lines, or comments as data, even if intended as a line or comment. 'MONO Correction Tape', by TOMBOW, may be used to make corrections instantly cleanly completely and remark the error directly on film. This product is a timesaving option. White out correction fluid may also be used to correct marks made in error. Apply a thin coat; thick fluid jams the form in the scanner. In addition, use care not to white out any of the black marks along the left side of the form. Do not make any marks or let white out run in the lower left corner of the form (below "Outcome" and "Why Selected").

DISPOSITION OF FORM

Field providers will send completed F-1612 data forms to ICEMA for data processing and quality assurance review 30 days following the run date. Agencies using electronic data submission will also send their data 30 days following the run date.

WHEN TO COMPLETE A FORM

For every patient contact, including interfacility transfers, an F-1612 data form is required. If more than one patient is at the scene, a separate form must be completed for each patient. If two providers are dispatched to the same scene, each ALS provider who makes patient contact must complete an F-1612 data form. **Items recorded on the forms should reflect only those services provided by the person(s) completing the form.** For example, when one ALS unit arrives first on the scene, the paramedic would record all care rendered to the patient on their F-1612 data form. If another ALS provider takes over care, the second paramedic would record treatment performed by its personnel on a separate F-1612 data form and will write the ICEMA number of the form completed by the first ALS provider in the space for "Other ICEMA #."

EMERGENCY CALLS

For every emergency call where patient contact is made, all sections must be completed on the F-1612 data form. **Exceptions are as follows:**

1. Mechanisms of injury should be blank for non-trauma patients.

DELETE

2. EKG rhythm should be blank if no EKG is done.
3. Medications administered should be left blank if no medications where given.

INTERFACILITY TRANSFERS

In addition to the 01A narrative form, the F-1612 data form must be completed for all ALS interfacility transfers. If a hospital request a BLS transfer but they send a paramedic on the run (with or without an EMT-I), an F-1612 data form is required. If the provider makes a BLS transfer with a nurse but no paramedic, we require only the 01A form.

ALS interfacility transfers (paramedic on the unit) require both an F-1612 data form and a 01A Narrative form. The following F-1612 data form items are to be marked for ALS interfacility transfers:

1. patient sex, age, and zip code
2. number of patients
3. incident number
4. rundate (date transported)
5. city code (for the city where the transferring facility is located)
6. run code to the scene
7. category (marked "transfer")
8. receiving hospital code
9. times call for transport received
10. time enroute
11. time of arrival at transferring hospitals
12. time departed a transferring hospital
13. time arrived at destination facility
14. systolic BP, respiratory rate and effort, capillary refill, eye opening
15. verbal response, motor response
16. care rendered (ALS or BLS if any during transport)
17. response to treatment rendered and time administered
18. medications (Note: Medications that are being monitored, i.e. Magnesium Sulfate drips)
19. patient condition (change/no change enroute)
20. outcome
21. attendant accreditation/certification numbers
22. provider and unit codes

CANCELED CALLS

A call is considered “canceled enroute” when the dispatcher notifies the unit that they have canceled the call before the unit arrives on a scene or before patient contact is made.

DELETE

The following F-1612 data form items are to be marked for calls canceled enroute:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes ("canceled enroute")
8. attendant accreditation/certification number(s)
9. provider and unit numbers

DRY RUNS

For data collection a “dry run” is a call on which **no patient contact is made at the scene**. Although the 01A form is not required for this type of run, an F-1612 data form is required. If patient contact is made at the scene and refuses treatment or transport, the F1612 data form is still required.

The following F-1612 data form items are to be marked for dry runs:

1. incident number
2. run dates
3. incident city code
4. run code to the scene
5. time call received
6. time enroute to the scene
7. call outcomes (“dry run-no pt.”)
8. Attendant accreditation/certification number(s)
9. Provider and unit numbers

DETAILS FOR COMPLETING THE F-1612 PCR DATA COLLECTION FORM

The F-1612 data form should be completed as soon as possible after the call, while the details of the run are fresh in your mind. All marks on the form must appear within the "boxes." *Data recorded here must match corresponding items on the 01A Narrative form for the patient*. No extra comments or writing should appear on the F-1612 data form, as the scanner will read the data incorrectly.

SEX (*Fieldname: GENDER*)

To show the patient's gender, mark the appropriate box **(M)ale, (F)emale** or **(U)nknown** (if the sex cannot be determined). **Do not mark more than one box**. The scanner reads a

DELETE

mark in the box for “M” that extends into the next box for “F” as a question mark, causing an error in the data.

AGE

Mark two numbers, **(0-9)**. Mark the numbers under the heading "Age" that match the number of whole years in the patient's age. If the patient is less than one year old, mark two zeroes ("00"). If they state the patient’s age as “18 months,” mark ("01") in the numbers below “Age.” If they state the patient’s age in half-years, for example as "two and a half," record only the whole number of years (marking the numbers "02"). If the patient is more than 99 years old, mark two nines ("99"). When the patient is obviously dead, attempt to get age from another party at the scene who knows the patient, or estimate the patient's age.

ZIP

Mark the numbers **(0-9)** beneath the heading "Zip" that represent the **first five digits of the patient's zip code**. If the patient is homeless or in transition or for some other reason has no zip code, make no marks in this section. For patients from outside the United States, mark 99999.

#PTS (*Fieldname:* PTS)

Record the number of patients encountered under the heading "# Pts" by marking the box with the appropriate number **(0-9)**. If you encounter more than nine patients at the scene, mark the box for ">9". Both the 01A Narrative form and F-1612 data form must be completed for each patient. This item is used to count multi-casualty incidents for statistical reporting. For example, a three-victim motor vehicle accident would have three forms, with "Number patients" marked "3" on each form--three different ICEMA numbers, with one incident number.

INCIDENT #

Mark eight boxes **(0-9)**. Using the dispatch number recorded on the *01A narrative under "Prim. Inc. #,”* mark the corresponding numbers below the heading for "Incident #." If the incident number is less than eight digits, mark zeroes to fill the boxes to the left of the incident number.

RUNDATE (*Fieldnames:* RUN-YEAR1 (9,0,1)/RUN-YEAR2 (0-9)/RUN-MONTH (0-9)/RUN-DAY (0-9))

Mark six boxes. Mark the numbers below the heading "rundate" that match the date written *in the "Date" area of the 01A Narrative*. Use 6-digit format and marking zeroes as necessary for the month and day, year, e.g., 06/01/02.

DELETE

DELETE

CITY

Mark three boxes **(0-9)**. Refer to the Incident City Codes listed on the back of the F-1612 data form. Find the three-digit code number across from the name of the city where the incident occurred. Mark the numbers beneath the heading "City" that represent this three-digit city code

RUN CODE (*Fieldnames:* RUN TO CODE/RUN FR CODE)
Definitions:

(1) Non-Emergent, no lights or sirens
(2) Urgent, obeying all traffic regulations, no lights or sirens
(3) Emergent, with lights and sirens
RUN TO CODE: Mark the number **(1, 2 or 3)** of run codes enroute to the scene. This should be the same number as that circled for *"Received Code" on the 01A Narrative*:
RUN FR CODE: Mark the number **(1, 2 or 3)** of run codes from the scene to the receiving. This should be the same number as circled for *"Depart Code" on the 01A Narrative*. If you make no transport, leave this item blank.

OTHER TRANSPORT PROVIDER/UNIT (*Fieldnames*: PROVIDER A/UNIT A)

Record the provider code **(0-9)** of another provider on scene. If your unit is the first on a scene and transfer patient care to another unit for transport, refer to the "Other Provider" area of the 01A Narrative. The transporting Provider Code list is on the back of the F-1612 data form. For fire departments, this code is "000." Record the 3-digit provider code and the unit number of the transporting unit. Complete this section only if a second unit is on scene and makes patient contact. **Use 777 for transport by any private car, truck, or other vehicle** that transports the patient (citizen transport). **Use 888 for transport by any provider that does not have an assigned code**, including transport by agencies outside the region.

TRANSP CODE1 (OTHER TRANSPORT)

Mark the type of unit **(MA, MS, ME, AM, SQ, E)** for another provider on scene. Enter this information only if a second unit is on scene and makes patient contact.

(MA) Medic Ambulance
(MS) Medic Squad
(ME) Medic Engine
(AM) Ambulance
(SQ) Squad
(E) Engine.

OTHER ICEMA# (*Fieldname:* ICEMA#1)

Enter another agency's O1A Narrative form number whenever another ALS provider agency is on scene and makes contact with the same patient. (*You mark their 01A number on your F-1612 data form, and they mark your 01A number on their F-1612 data form in the "Other ICEMA #" box*.) Fill this in whenever another 01A Narrative form exists for the same patient. If only one 01A form exists for a patient, this area should be blank.

PRIOR CARE

Mark the **one** appropriate box **(N, M, B, C, O, L, A)** to show the person or agent providing care or treatment to the patient prior to arrival of the prehospital field personnel completing this form.

1. **(N)none**: no care given to the patient prior to arrival of this unit.
2. **(M)medical**: a physician, nurse, or other medical person on a scene provided care.
3. **(B)FD/BLS**: a BLS unit provided prior care.
4. **(C)citizen**: a citizen, bystander, or relative provided care.
5. **(O)other**: Some person gave prior care not fitting any of the defined categories.
6. **(L)law enf.** police, sheriff, or other law enforcement personnel provided care.
7. **(A)FD/ALS**: another ALS unit provided prior care.

MECH. OF INJURY-TRAUMA ONLY (*Fieldname:* INJURY MECH)

Mark the space next to the **one** category **(M, C, G, S, A, D, F, B, L, T, E, P, O, U)** that best describes the mechanism of injury precipitating this call**. This section should be left blank for non-trauma cases**.

(M)auto/truck-MVA: any traffic incident, except those involving motorcycles. This includes an auto vs. an auto, auto vs. truck, pedestrian vs. autos, single vehicle collisions, etc.

SEATBELT: **(Y)es or (N)o** to show if the patient was wearing a seatbelt or other safety restraint device. Must be completed for all motor vehicle accident calls.

(C)motorcycle: any traffic related incident involving a motorcycle or bicycle. This includes autos vs. motorcycle, motorcycle vs. pedestrian, bicycle vs pedestrian, etc.

HELMET: **(Y)es or (N)o** to show if the patient was wearing a protective helmet. Must be completed for all traffic-related incidents involving motorcycles.

(G)gunshot: any call involving injury from a firearm, including a pistol, shotgun, rifle, or other similar weapon.

DELETE

(S)stabbing: a penetrating injury by a knife or other sharp object.

(A)assault: any injury resulting from assault other than a gunshot wound or stabbing.

(D)near-drowning: conditions resulting from submersion that deprives the patient of oxygen.

(F)fall >20' : injury resulting from a fall from a building, ladder, or other place estimated at more than 20 feet from the area where the patient landed. Do not use this category for slips or short-distance falls such as a fall in the bathtub. **For short falls, mark "blunt injury" or "penetrating injury"** as appropriate.

(B)bite/sting: injury from any type of animal, insect bite or sting; e.g., snakes, bee, a dog bite.

(L)blunt injury: an accidental injury in which the skin is unbroken or only slightly opened.

(T)multiple mech.: more than one mechanism of injury none more notable than another. If more than one mechanism, but one dominant injury occurs with other minor injuries, check the single category that caused the dominant injury.

(E)sports injury: an injury resulting from a sports related activity.

(P)oth penetrating: an injury other than stabbing which penetrates the skin and subcutaneous tissue.

(O)other: any condition not covered under the categories above, including ski, snow boarding and boating accidents.

(U)unknown: the mechanism of injury cannot be determined.

CATEGORY

Mark the **one** box **(T, C, R, A, B, 5, U, D, E, O, P, S, M, N)** next to the category that best fits this patient.

(T)trauma: any serious traumatic condition except cranial and/or spinal injury, assault involving domestic violence, or amputation. If you mark this box, you must **also mark "MECH. OF INJURY."** For **ski accidents**, mark this box and "**MECH OF INJURY" as (O)ther**.

(C)cardiac: all acute cardiopulmonary emergencies including myocardial infarction or suspected heart attack.

DELETE

(R)respiratory: choking incidents, asthma attacks, and other situations in which the patient's primary difficulty is failure to breathe adequately

(A)amputation: cases that involve potential re-implantation of a severed body part, cases involving complete or partial traumatic amputation of a body part.

(B)behavior/OD: intoxicated or psychologically disturbed patients, conditions related with alcohol or drug related syndromes including drug overdose, attempted suicide, and homicide victims; **does not include "5150" cases.**

(5)5150: patients transported to any mental health facility for 72-hour treatment and evaluation requested bylaw enforcement or other persons authorized to declare such treatment and evaluation

(U)burn: injury by fire, explosion, or chemical burn.

(D)domestic viol: calls involving child abuse or neglect, domestic partner abuse, elder abuse, or sexual assault. **Also specify "MECH. OF INJURY."**

(E)environment: diving casualties, radiation accidents, hypothermia, heat exhaustion, and other cases involving exposure to the elements. **Also specify "MECH. OF INJURY."**

(O)obstetric: problems relating to pregnancy, assistance with delivery, and postpartum emergencies.

(P)poisoning: emergencies resulting from ingestion, inhalation, or other exposure to toxic substances including intentional and accidental poisonings and hazardous materials' incidents; any call involving use of a poison control center.

(S)spinal inj: cranial and/or spinal trauma. **Specify "MECH. OF INJURY"**

(M)oth medical: other medical complaints such as diabetic complications, abdominal pain, or any medical problem involving a system other than the cardiac or respiratory system.

(N)transfer: any transfer of a patient from an acute care hospital to another facility.

BASE HOSP

Enter the base hospital code **(0-9)** only if BH was contacted. On the back of the F-1612 data form, find the name of the base hospital and the two-digit code next to the name. Mark the numbers corresponding to this code below the heading 'Base Hosp'.

DELETE

NO HOSPITAL CONTACT-USE CODE "89"

Mark (Y)es if no BH contact attempted/needed, RCF or contact was with receiving hospital only.

Note:

Base Hospital	No Contact	Interpreted As:
(blank)	Marked	no contact attempted/needed
Marked	Marked	radio communications failure (follow RCF protocol)
Marked	(blank)	successful base contact
(blank)	Marked	Contact with receiving hosp only.

RECV HOSP

On the reverse side of the F-1612 data form, find the name of the receiving hospital and mark the two-digit code number **(0-9)** here. Use code **"77" for all subacute or chronic care facilities** (e.g., nursing homes). Use code "**99" for destinations other than acute care hospitals, subacute or chronic care facilities** (e.g., a residence). If the patient refuses transport or if another provider is transporting the patient, leave this item blank.

TIMES

CALL RECD

Time call is first received by EMS Provider Agency. Mark the numbers **(0-9)** that match the *"Received" time from the 01A Narrative form.* Use military time (a 24-hour clock). Valid times range from 0000 (midnight) to 2359 (11:59 p.m.). DO NOT USE 2400. **Note**: For walk-in patients, the time call received is when the patient walks in the door; depart is when the patient leaves; and all other times are blank.

ENROUTE

Time that the response unit begins physical motion; i.e. wheels begin to turn. Mark the numbers **(0-9)** that match the *"Enroute" time from the 01A Narrative form*

ARRIVE (*Fieldname*: TIME ARRIVE)

Time the EMS unit stops physical motion at scene or staging area; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive" time from the 01A Narrative form*.

DEPART (*Fieldname:* TIME DEPART)

Time when the response unit begins physical motion from scene, i.e. when the wheels begin to turn. . Mark the numbers **(0-9)** that match the *"Depart" time from the 01A Narrative form*. If you transport a patient, record DEPART as the time the ambulance

DELETE

leaves the scene enroute to the hospital or other destination. If the unit completing the run is not transporting the patient, record DEPART as the time when the unit is available for another call. If the patient refuses transport, record DEPART time as the time that you leave scene.

ARV DEST/END CALL (*Fieldname*: ARV DESTIN)

Time when patient arrives at destination or transfer point; i.e. wheels stop turning. Mark the numbers **(0-9)** that match the *"Arrive Dest" time from the 01A narrative form.* Leave blank if your unit is not transporting the patient. Note: Time call ended; i.e. AMA, the time a non-transport provider transferred care to a transport provider.

PT REFUSES CARE (*Fieldname*: REFUSE CARE)

Mark this area **(Y)** when a patient declines **all** prehospital treatment. In such situations, the patient must also sign the medical release section on the back of the first copy of the 01A Narrative form. If the patient refuses one or more specific types of care, document the type of care refused in the Narrative/Assessment section of the 01A narrative form.

RELEASE SIGNED

Mark this box **(Y)** when the patient refuses treatment and completes the "Medical Liability Release Form" on the *back of the first copy (white) of the 01A Narrative form*.

MEDICATIONS (*Fieldname*: MEDICATION)

Mark as many boxes **(A, H, B, J, P, D, 1, 2, E, Q, F, G, I, L, R, S, M, N, 3, W, C, 4, V, U)** as apply. Mark ONLY the box(es) given by the unit recording this run. The medications are listed alphabetically; **(A)act. charcoal, (H)adenosine, (B)albuterol, (J)aspirin, (P)atropine, (D)dextrose, (1)diphenhydram, (2)dopamine, (E)epineph-IV, (Q)epineph-SQ, (F)furosemide, (G)glucagon, (I)ipratropium bromide ATROVENT, (L)lidocaine, (R)magnesium, (S)midazolam, (M)morphine, (N)naloxone, (3)nitroglycerine, (W)phenylephrine, (C)procainade, (4)sodium bicarb, (V)verapamil, (U)other med, for medication(s) administered but not listed.** For Interfacility Transfers, mark boxes for medication that are being monitored by the EMT-P during the transfer.

CARE RENDERED (*Fieldnames*: CARE1/CARE2)

For service or treatment provided, mark as many boxes as apply in the BLS (left column) **(F, A, M, B, P, D, E, C, H, K, N, O, X, G, I, S, T, L, W, U)** or ALS (right column) **(B, I, D, E, T, J, F, G, 1, 2, 3, 4, O, P, N, C, K, Y, H, V, U)**. Mark each treatment or procedure only once, though it may have been done for this patient several times. Mark only those services provided by your unit. Document services provided by non-EMS individuals or other agencies in the "Narrative/Assessment" section of the 01A form. Other agencies

DELETE

must document services provided by their agency on their O1A form and F-1612 data form.

BLS SERVICES(*Fieldname*: CARE 1):(Care Rendered [Left Column])

(F)AED: when used on patient

(A)bag-valve mask: on resuscitation

(M)burn care: on burns

(B)axial spinal stabilization: on patient

(P)CPR/resuscitation: when preformed on patient

(D)decontamination: usually associated with exposure to hazardous materials

(E)extrication: from a vehicle or hazardous situation; if time > than 10 minutes, record the approx. time in the Narrative/Assessment section of the 01A form

(C)hard collar: to immobilize the neck

(H)hot/cold packs: on patient

(K)KED: on patient

(N)NP/OP airway: on attempts to establish a nasopharyngeal or oral pharyngeal airway

(O)OB assist: on assistance with obstetrical delivery

(X)oxygen: on administration to patient

(G)sand bags: used for patient

(I)snake bite kit: on patient

(S)splint, simple: on patient

(T)splint, traction: on patient

(L)suction: on patient

(W)wound dressing: on patient

DELETE

(U)BLS Other: for a BLS procedure other than those listed

ALS SERVICES (*Fieldname*: CARE 2):(Care Rendered [Right Column])

(B)blood drawn: on patient

(I)CPAP: on patient

(D)dexstick: on patient

(E)ECG monitor: on patient (**also mark the "1 ST ECG" section**)

(T)ECG strip: on patient

(F)12 lead ECG: on patient

(G)McGill forceps: on an attempted or performed foreign body removal

(1)Meds given IV: route given to pt

(2)Meds given IO: route given to pt

(3)Meds given ET: route given to pt

(4)Meds given PO: route given to pt

(O)monitor chest tubes: on an attempted, inserted a chest tube, or monitored

(P)needle thoracostomy: on an attempted or performed needle thoracostomy

(N)NG insertion: on an attempted, inserted or monitored NG tube

(C)Percutaneous Needle Cric: if attempted, or inserted

(Q)Pulse Ox: on patient

(Y)Approved Device: Quick Trach Device

(H)TCP: if attempted or placed

(V)Valsalva maneuver: on patient

(U)ALS Other:for an ALS procedure other than those listed, for transfer patients mark this box if EMT-P is monitoring IV medication during the transfer.

DELETE

SYS BP

Mark the box **(4-0)** next to the category in which the patient's initial systolic blood pressure reading falls. If no systolic BP is present, mark the space for "0." Blood pressures are usually obtainable on pediatric patients with a pediatric BP cuff. If you obtain no BP, leave this area blank. **LIST ONLY VITAL SIGNS TAKEN BY YOUR AGENCY**.

RESP RATE

Using the **first** observation of the patient's respiratory rate, mark the box **(4-0)** next to the category in which the patient's rate (in number of respiration's per minute) occurs. For example, if the patient's respiration rate is 20, mark the top space, numbered 4.

EFFORT

Referring to **initial** respiratory effort (chest wall movement), mark the box **(1 or 0)** next to the category that better describes the situation for this patient~normal, or shallow/refractive/none.

CAP REFILL

Mark the box **(2, 1, 0)** that best describes the patient's capillary refill upon **initial assessment**.

BEST MOTOR (*Fieldname*: MOTOR)

Mark the box **(6-1)** next to the patient's **initial** best motor response.

BEST VERBAL (*Fieldname*: VERBAL)

Mark the box **(5-1)** next to the category that describes this patient's **initial** best verbal response.

EYE OPEN
Note the patient's **initial** ability to open his/her eye(s). Mark the box **(4-1)** next to the category**.**

(R)cardiovert (D)defib (*Fieldname*: D-FIB)
Mark **(R)CARDIOVERT (D)DEFIB** if performed by the unit recording this run.

1ST ECG
Mark **one** box **(N, B, T, V, C, D, I, L, E, A, Y, O)** for the code of the **first rhythm detected** on EKG by unit recording this run, *as recorded on the 01A Narrative*.

DELETE

DELETE

(N)SR: Normal sinus rhythm
(B)SB: Sinus bradycardia; heart rate <60 beats per minute
(T)ST: Sinus tachycardia; heart rate >100 per minute
(V)Vfib: Ventricular fibrillation
(C)VT: Ventricular tachycardia (V tach)
(D)SVT: Super ventricular tachycardia
(I)Afib: Atrial fibrillation
(L)AFL: Atrial flutter
(E)AT: Atrial tachycardia
(A)AVB: Atrioventricular block (AV block) or heart block
(Y)ASY: Asystole
(O)Oth Unidentifiable rhythm

ATTEMPTS PLACED
IV (*Fieldnames*: IV ATTEMPT/IV2 ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place IV needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IV's, the number of IV attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IV took two tries before placement, mark "2," etc.

IO (*Fieldnames*: IO ATTEMPT/IO2 ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place IO needle. If successful, mark **(Y)**. For bilateral (or 3 or more) IO's, the number of IO attempts means the maximum number of attempts made to insert any of the needles. If both were placed successfully on the first try, mark "1." If one IO took two tries before placement, mark "2," etc.

ET (*Fieldnames*: ET1 ATTEMPT/ET1A ATTEMPT)

Mark **(1, 2, or 3+)** for three or more attempts to place tube. If successful mark **(Y).**

ET-NASAL (*Fieldname*: ET2 ATTEMPT)

Indicate placement of ET: **(N)**nasal or **(O)**oral.

PT CONDITION

Mark the patient's overall response to treatment. BLANK IS INVALID. This category refers to the patient's response to all treatment rather than to a specific drug or procedure. Mark **(C)changed** or **(N)no change** during transport.

IV/IO

Mark box for saline or **(S)** OR **(L)**

SPECIAL STUDY

Use this area whenever a special study is conducted. Mark all boxes **(M, S, or O)** that apply.

(M)Medications
(S)Skills
(O)other.

OUTCOME

Mark the box **(C, D, R, G, A, O)** next to the category that best describes this call. *BLANK IS INVALID*.

(C)canceled enroute: Call canceled by agency dispatcher prior to arrival at a scene and if the run is canceled on scene before you make pt contact.

(D)dry run-no pt No patient was found at the scene, the unit was unable to locate the scene or the patient, or the patient refuses to communicate so you cannot obtain any patient information.

(R)transport refused: The patient accepted care by an EMS field provider but refused to be transported by any EMS provider, and for walk-in patients.

(G)transport-ground: Patient received prehospital care, was transported by this or another ground ambulance, or if patient care was transferred to another unit.

(A)transport-air: Patient received prehospital care, was transported by helicopter or fixed-wing aircraft, and for patient to loading zone and patient care to EMS air.

(O)obviously dead: Patient showed obvious signs of death, per protocol.

WHY SELECTED

Mark the category **(S, T, P, D, C, E, R, O)** that most closely matches the reason for selection of the receiving hospital. If the base hospital indicates a reason, mark the hospital's determination of "why selected."

(S)Stemi: a stemi center is required.

DELETE

(T)major trauma: a trauma center is required.

(P)patient request: patient or patient's physician requests transport to a specific facility

(D)diversion: the original receiving hospital selected was on diversion

(C)closest: the hospital is closest to the scene.

(E)peds trauma: pediatric trauma center is required.

(R)reroute: the receiving hospital destination changed while the unit was enroute (e.g., a change in patient condition required selection of a different facility). Does not include change in a destination based upon hospital status

(O)other: a reason other than those listed was used in selecting the receiving hospital.

ICEMA# (*Fieldname*: ICEMA#2)

Mark six boxes **(0-9**) to indicate the ICEMA number printed on the upper left corner of the 01A Narrative form for this patient. An ICEMA number is required here, **except for dry runs or canceled calls**.

ATTENDANT #1 CERT NO (*Fieldnames*: CERT#1A/CERT#1B)

Mark the first box **(E, L, P, or M)** to indicate the level of accreditation/certification for primary patient caregiver reporting on this run. P for paramedic, E for emergency medical technician, or M for mobile intensive care nurse (on interfacility transfers). Mark the ICEMA accreditation/certification numbers **(0-9)** in the remaining boxes**.** If your ICEMA number is less than five digits, use leading zeroes before the number as needed to fill the boxes. **Provisional paramedics or MICNs who are third members of the ambulance crew sign the 01A narrative form, but enter no data on the F-1612 data form.**

ATTENDANT #2 CERT NO (*Fieldnames*: CERT#2A/CERT#2B)

Mark the first box **(E, L, P, or M)** to indicate the type of accreditation/certification for the secondary patient caregiver reporting on this run. Mark the ICEMA accreditation/certification number **(0-9)** in the remaining boxes. If your number is less than five digits, use leading zeroes before the number as needed to fill the boxes

THIS FORM BY PROVIDER/UNIT (*Fieldnames*: PROVIDER B/UNIT B)
Obtain your 3-digit provider code from the list on the back of the F-1612 data form. Mark the box with these three digits **(0-9)** below "Provider." For all agencies, mark three

DELETE

numbers that represent the unit number of the vehicles in which you are riding on this call. Use leading zeroes.

TRANSP CODE2 (THIS FORM BY)
Enter the type of unit for the agency reporting this run.

(MA)Medic Ambulance
(MS)Medic Squad
(ME)Medic Engine
(AM)Ambulance
(SQ)Squad
(E)Engine

REVERSE SIDE OF F-1612 DATA FORM

PUBLIC PROVIDERS

Fire department EMS providers, use provider code followed by the unit type (MA, ME, MS, AM, SQ, E) and three-digit unit number as assigned by Fire Chiefs. **Use code 888 for other Public Providers outside the ICEMA region**.

PRIVATE PROVIDERS

A three-digit code is assigned to each private ALS or BLS provider agencies within the region. Provider codes are used in the area for "Other Transport Provider" on the F-1612 data form (upper right corners) as well as for the "This Form By" provider code in the lower right corner. Codes are organized alphabetically by county. The provider code is followed by a three-digit unit number assigned by ICEMA, e.g., 001. **Use code 999 for other Private Providers outside the ICEMA region.**

HOSPITAL CODES

Two-digit code numbers have been assigned to each hospital within the ICEMA region. These codes are used in the "Base Hospital" and "Receiving Hospital" areas of the F-1612 data form. They are listed alphabetically by hospital name. **Use code 88 for all hospitals outside the ICEMA region**.

INCIDENT CITY CODES

These three-digit code numbers are to be used to complete the "City" area in the upper right portion of the F-1612 data form. To find a code, first locate the section of the form for the appropriate county within the region (Inyo, Mono, or San Bernardino). For San Bernardino County, check the subheadings for the appropriate geographical area (e.g., West Valley or High Desert). Cities and communities are listed alphabetically within the county or area.

DELETE

If the city or community where the incident occurred is not listed, use the code for the city or community nearest to the incident location; if none, use the code for "Inyo Co. Other," "Mono Co. Other," or "San Bernardino Co. Other," as appropriate

DELETE

BLS/LALS/ALS STANDARD DRUG & EQUIPMENT LIST

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

All ALS (transport and non-transport) and BLS transport vehicles shall be inspected annually.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Adenosine (Adenocard) 6 mg			1	1
Adenosine (Adenocard) 12 mg			2	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg		4 doses	4 doses	4 doses
Albuterol MDI with spacer		1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY
Aspirin, chewable - 81 mg tablet		2	1 bottle	1 bottle
Atropine 1 mg preload			2	2
Calcium Chloride 1 gm preload			1	1
Dextrose 10% in 250 ml Water (D10W) *		2	2	2
Diphenhydramine (Benadryl) 50 mg			1	1
Dopamine 400 mg			1	1
Epinephrine 1:1000 1 mg		2	2	2
Epinephrine 1:10,000 1 mg preload			3	3
Glucagon 1 mg		1	1	1
Glucose paste	1 tube	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg			4	4
Irrigating Saline and/or Sterile Water (1000 cc)	2	1	1	2
Lidocaine 100 mg			3	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W			1	1
Lidocaine 2% Intravenous solution			1	1
Lidocaine 2% (Viscous) dose			1	1
Magnesium Sulfate 10 gm			1	1
Naloxone (Narcan) 2 mg preload		2	2	2
Nitroglycerine - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening)		2	1	2
Normal Saline for Injection (10 cc)		2	2	2

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Normal Saline 100 cc			1	2
Normal Saline 250 cc			1	1
Normal Saline 500 ml and/or 1000 ml		2000 ml	3000 ml	6000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)			4	4
Ondansetron (Zofran) 4 mg IM/ IV			4	4
Phenylephrine HCL - 0.5 mg per metered dose			1 bottle	1 bottle
~~Procainamide 1 gm~~			~~1~~	~~2~~
Sodium Bicarbonate 50 mEq preload			2	2
~~Verapamil 5 mg~~			~~3~~	~~3~~

CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange Controlled Substance Medications MUST BE DOUBLE LOCKED	BLS	LALS	ALS Non-Transport	ALS Transport
Fentanyl			200-400 mcg	200-400 mcg
Midazolam			20-40mg	20-40mg

AIRWAY/SUCTION EQUIPMENT

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

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Nasopharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Needle Cricothyrotomy Device - Pediatric and adult or Needles for procedure 10, 12, 14 and/or 16 gauge			1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent			1	1
Oropharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Rigid tonsil tip suction	1		1	1
Small volume nebulizer with universal cuff adaptor		2	2	2
Suction Canister	1		1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each		1 each	1 each
Ventilation Bags - Infant 250 ml Pediatric 500 ml (or equivalent) Adult	 1 1 1	 1 1 1	 1 1 1	 1 1 1
Water soluble lubricating jelly		1	1	1

Non-Exchange Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Ambulance oxygen source -10 L /min for 20 minutes	1			1
Flashlight/penlight	1	1	1	1
Laryngeal blades - ~~#0, #1, #2,~~ #3, #4 curved and/or straight			1 each	1 each
Laryngoscope handle with batteries - or 2 disposable handles			1	1
Magill Forceps - Pediatric and Adult			1 each	1 each
Manual powered suction device		1		
Portable oxygen with regulator - 10 L /min for 20 minutes	1	1	1	1
Portable suction device (battery operated)	1		1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1	1
Stethoscope	1	1	1	1
Wall mount suction device	1 (BLS TRANSPORT ONLY)			1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Conductive medium or Pacer/Defibrillation pads			2 each	2 each
Disposable Tourniquets		2	2	2
ECG electrodes			20	20
EZ-IO Driver			1 each	1 each
EZ-IO Needles: 25 mm 45 mm			 2 each 1 each	 2 each 1 each
Glucose monitoring device with compatible strips and OSHA approved single use lancets		1	1	1
3-way stopcock with extension tubing			2	2
IV Catheters - sizes 14, 16, 18, 20, 22, 24		2 each	2 each	2 each
Macrodrip Administration Set Microdrip Administration Set (60 drops /cc)		3 1	3 1	3 2
Mucosal Atomizer Device (MAD) for nasal administration of medication		2	2	4
Pressure Infusion Bag (disposable)		1	1	1
Razors		1	2	2
Safety Needles - 20 or 21gauge and 23 or 25 gauge		2 each	2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2	2
Sterile IV dressing		2	2	2
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc catheter tip		2 each		
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc, 20 cc, 60 cc catheter tip			2 each	2 each

Non-Exchange IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
12-lead ECG Monitor and Defibrillator with TCP and printout			1	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant (one of each size)	1	1	1	1
Capnography monitor and supplies, may be integrated in the cardiac monitor			1	1
Needle disposal system (OSHA approved)		1	1	1
Thermometer - Mercury Free with covers	1	1	1	1

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	LALS	ALS Non-Transport	ALS Transport
AED/defib pads - Adult (1), Pediatric (1)	1 each	1 each		
Ammonia Inhalants			2	2
Automatic CPR device (FDA approved)	1	1	1	1
Automatic ventilator (ICEMA approved)			1	1
Backboard padding	1	1	1	1
Buretrol			1	1
Chemistry profile tubes			3	3
CPAP - (must be capable of titrating pressure between 2 and 15 cm H_2O)	1 (optional)	1 (optional)	1	1
CyanoKit (Specialty Program Only)			1	1
EMS Tourniquet	1		1	1
Endotracheal Tubes, cuffed - 2.5, 3.0, 3.5 with stylet			SPECIALTY PROGRAMS ONLY	SPECIALTY PROGRAMS ONLY
Endotracheal Tubes, cuffed - 4.0 or 4.5, 5.0 or 5.5 with stylet			SPECIALTY PROGRAMS ONLY	SPECIALTY PROGRAMS ONLY
Gum Elastic intubation stylet			2	2
Hemostatic Dressings *	1	1	1	1
IO Needles - Manual, Adult and Pediatric, Optional		Pediatric sizes only or EZ-IO needles and drivers	1 each	1 each
IV infusion pump			1	1
IV warming device		1	1	1
Manual IV Flow Rate Control Device			1	1
Manual powered suction device	1	1	1	1
Multi-lumen peripheral catheter			2	2
Needle Thoracostomy Kit (prepackaged)			2	2
~~Pitocin~~			~~20 units~~	~~20 units~~
Pulse Oximetry device	1			
Translaryngeal Jet Ventilation Device			1	1
Vacutainer			1	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are "packaged" in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4"x4"pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Exchanged Dressing Materials/Other Equipment/Supplies	**BLS**	**LALS**	**ALS Non-Transport**	**ALS Transport**
Adhesive tape - 1 inch	2	2	2	2
Air occlusive dressing	1	1	1	1
Ankle and wrist restraints, soft ties acceptable	1		1	1
Antiseptic swabs/wipes		10	10	10
Bedpan or fracture pan Urinal	1(BLS TRANSPORT UNITS ONLY 1(BLS TRANSPORT UNITS ONLY			1 1
Cervical Collars - Rigid Pediatric and Adult all sizes or Cervical Collars - Adjustable Adult and Pediatric	2 each 2 each	2 each 2 each	2 each 2 each	2 each 2 each
Cold Packs	2	2	2	2
Emesis basin or disposable bags and covered waste container	1	1	1	1
Head immobilization device	2	2	2	2
OB Kit	1	1	1	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	2	4
Provodine/Iodine swabs/wipes or antiseptic equivalent		4	10	10
Roller bandages - 4 inch	6	3	3	6
Sterile bandage compress or equivalent	6	2	2	6
Sterile gauze pads - 4x4 inch	4	4	4	4
Sterile sheet for Burns	2	2	2	2
Universal dressing 10x30 inches	2	2	2	2

Non-Exchange Dressing Materials/Other Equipment/Supplies	**BLS**	**LALS**	**ALS Non-Transport**	**ALS Transport**
800 MHz Radio		1	1	1
Ambulance gurney	1(BLS TRANSPORT UNITS ONLY			1
Bandage shears	1	1	1	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2	1	2	2
Drinkable water in secured plastic container or equivalent	1 gallon			1 gallon
Long board with restraint straps	1	1	1	1
Pediatric immobilization board	1	1	1	1
Pillow, pillow case, sheets and blanket	1 set (BLS TRANSPORT UNITS ONLY			1 set

Non-Exchange Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
Short extrication device	1	1	1	1
Straps to secure patient to gurney	1 set (BLS TRANSPORT UNITS ONLY			1 set
Traction splint	1	1	1	1
Triage Tags - CAL Chiefs or ICEMA approved	20	20	20	20

EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

MEDICATIONS/SOLUTIONS	AMOUNT
Adenosine (Adenocard) 6 mg	1
Adenosine (Adenocard) 12 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg	3 doses
Aspirin, chewable - 81 mg tablet	1 bottle
Atropine 1 mg preload	2
Calcium Chloride 1 gm preload	1
Dextrose 10% in 250 ml Water (D10W) *	2
Diphenhydramine (Benadryl) 50 mg	1
Dopamine 400 mg	1
Epinephrine 1:1,000	2
Epinephrine 1:10,000	2
Glucagon 1 mg	1
Glucopaste	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg	3
Lidocaine 100 mg	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W	1 gm
Lidocaine 2% Intravenous solution	1
Lidocaine 2% (Viscous)	1 dose
Magnesium Sulfate 10 gms	1
Naloxone (Narcan) 2 mg preload	2
Nitroglycerin - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening.)	1
Normal Saline for Injection (10 cc)	2
Normal Saline 250 ml	1
Normal Saline 500 ml and/or 1000 ml	2000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5 mg per metered dose	1 bottle
~~Procainamide 1 gm~~	~~1~~
Sodium Bicarbonate 50 mEq preload	2
~~Verapamil 5 mg~~	~~3~~

CONTROLLED SUBSTANCE MEDICATIONS-MUST BE DOUBLE LOCKED	AMOUNT
Fentanyl	200-400 mcg
Midazolam	20-40 mg

AIRWAY/SUCTION EQUIPMENT	AMOUNT
Aircraft Oxygen source -10 L /min for 20 minutes	1
BAAM Device	1
C-PAP circuits - all manufacture's available sizes	1 each
End-tidal CO2 device - pediatric and adult (may be integrated into bag)	1 each
~~Endotracheal tubes, uncuffed - 2.5, 3.0, 3.5 with stylet~~	~~2 each~~
~~Endotracheal Tubes, uncuffed - 4.0 or 4.5, 5.0 or 5.5 with stylet~~	~~2 each~~
Endotracheal Tubes cuffed - 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet	2 each
ET Tube holders - ~~pediatric and~~ adult	1 each
Flashlight/penlight	1
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	1 each
King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange)	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1
Laryngeal blades - ~~#0, #1, #2,~~ #3, #4 curved and/or straight	1 each
Magill Forceps - Pediatric and Adult	1 each
Nasal Cannulas - infant, pediatric and adult	2 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Nasopharyngeal Airways - infant, child, and adult	1 each
Needle Cricothyrotomy Device (Approved) - Pediatric and adult *or* Needles for procedure 10, 12, 14 and/or16 gauge	1 each 2 each
Non Re-Breather O_2 Mask - Pediatric and Adult, Infant Simple Mask	2 each
One way flutter valve with adapter or equivalent	1
Oropharyngeal Airways - infant, child, and adult	1 each
Portable Oxygen with regulator - 10 L /min for 20 minutes	1
Portable suction device (battery operated) *and/or* Wall mount suction device	1 each
Pulse Oximetry device	1
Small volume nebulizer with universal cuff adaptor	1
Stethoscope	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags - Infant 250 ml, Pediatric 500 ml and Adult 1 L	1 each
Water soluble lubricating jelly	1
Ridged tonsil tip suction	1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT	AMOUNT
12-Lead ECG Monitor and Defibrillator with TCP and printout	1
800 MHz Radio	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant	1 set
Capnography monitor and supplies, may be integrated in the cardiac monitor	1
Conductive medium *or* Adult and Pediatric Pacer/Defibrillation pads	2 each
ECG - Pediatric and Adult	20 patches
EZ IO Needles and Driver 25 mm and 45 mm	2 each 1 each
3-way stopcock with extension tubing	2
IO Needles - Manual, Adult and Pediatric, Optional	1 each
IV Catheters - sizes 14, 16, 18, 20, 22, 24	2 each
Glucose monitoring device	1
Macrodrip Administration Set Microdrip Administration Set (60 drops/ml)	3 1
Mucosal Atomizer Device (MAD) for nasal administration of medication	4
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Safety Needles - 20 or 21 gauge and 23 or 25 gauge	2 each
Saline Lock	2
Syringes w/wo safety needles - 1 ml, 3 ml, 10 ml, 20 ml	2 each
Syringe - 60 ml catheter tip	2
Thermometer - Mercury free with covers	1

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Adhesive tape - 1 inch	2
Air occlusive dressing	1
Aircraft stretcher or litter system with approved FAA straps that allows for Axial Spinal Immobilization	1
Ankle and wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Bandage shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2
Cervical Collars - Rigid Pediatric & Adult all sizes *or* Cervical Collars - Adjustable Adult and Pediatric	1 each 1 each
Emesis basin or disposable bags and covered waste container	1
Head immobilization device	1
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4
Provodine/Iodine swabs/wipes or antiseptic equivalent	
Roller bandages - 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads - 4x4 inch	4

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Sterile Sheet for Burns	2
Traction splint	1
Universal Dressing 10x30 inches	2

OPTIONAL EQUIPMENT/MEDICATIONS	Amount
Ammonia Inhalants	2
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
Chemistry profile tubes	3
CyanoKit (Specialty Program Only)	SPECIALTY PROGRAMS ONLY
D5W in bag	1
~~Endotracheal tubes, cuffed - 2.5, 3.0, 3.5 with stylet~~	~~SPECIALTY PROGRAMS ONLY~~
~~Endotracheal Tubes, cuffed - 4.0 or 4.5, 5.0 or 5.5 with stylet~~	~~SPECIALTY PROGRAMS ONLY~~
Hemostatic Dressing *	1
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Medical Tourniquet	1
Needle Thoracostomy Kit (prepackaged)	2
Pediatric immobilization board	1
~~Pitocin~~	~~2~~
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, and 4”x4” pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

MEDICATION - STANDARD ORDERS

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/IM/IN
9 to 14 years	Naloxone, 0.5 mg IV/IO/IM/IN

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_2 at 94%.
Do not administer supplemental oxygen for $SPO_2 > 95\%$

Chronic Obstructive Pulmonary Disease (COPD):

Titrate Oxygen at lowest rate required to maintain SPO_2 at 90%
Do not administer supplemental oxygen for $SPO_2 > 91\%$

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*~~

INTERFACILITY TRANSFER GUIDELINES

I. PURPOSE

To identify patient care responsibilities for emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics (EMT-Ps) during interfacility transports.

~~II. AUTHORITY~~

~~California Health and Safety Code, Division 2.5, Sections 1797.214, 1798.170 and 1798.172.~~

~~III~~II. BLS INTERVENTIONS

During an interfacility transport, an EMT may monitor the following if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via BLS ambulance:

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

- Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
  - No medications have been added to the IV fluid.
  - Maintain the IV at a pre-set rate.
  - Check tubing for kinks and reposition arm if necessary.
  - Turn off IV fluid if signs/symptoms of infiltration occur.
  - Control any bleeding at insertion site.
- Transport a patient with a urinary catheter provided the following:
  - The catheter is able to drain freely.
  - No action is taken to impede flow or contents of drainage collection bag.
- Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped.

- If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

~~IV~~III. LIMITED ALS (LALS) INTERVENTIONS

During an interfacility transport, if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via LALS ambulance, an AEMT may monitor or perform the following:

- Peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Saline locks.
- Tracheo-bronchial suction of an intubated patient.
- Initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

AEMTs may not transport a patient with IV drips that are not in the AEMT scope of practice.

AEMTs may not transport patients with blood or blood products.

IV. ALS INTERVENTIONS

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

If the transfer is a STEMI patient, refer to ICEMA Reference#8040 - Continuation of Care of a STEMI Patient (San Bernardino Only).

EMT-Ps may not transport a patient with IV drips that are not in the EMT-P scope of practice.

EMT-Ps may not transport patients with blood or blood products.

During an interfacility transport, an ICEMA accredited EMT-P may:

- Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.

- Transport intravenous solutions with added medication(s) as follows:
  - Lidocaine
  - Dopamine
  - ~~Procainamide~~
  - Magnesium Sulfate
  - ~~Pitocin~~
- Monitor and administer medications through a pre-existing vascular access.
- Monitor heparin lock or saline lock.
- Monitor IV solutions containing potassium ≤40mEq/L.
- Monitor thoracostomy tubes to water or dry sealed drainage.
- Monitor nasogastric tubes.
- EMT-Ps may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

V~~I~~. NURSE ASSISTED ALS TRANSPORT

In the event of a critical patient that needs transport with medication or IV drips that are outside of the EMT-P scope of practice and CCT transport is not possible, a Registered Nurse (RN) from the transferring hospital may accompany the patient. The RN will be responsible for orders from the transferring physician. In the event the patient condition deteriorates, the EMT-P will contact the Base Station for orders and destination change. The RN will continue to provide care consistent with the transferring physician's orders. The Base Station physician may consider discontinuing or continuing the prior orders based on patient condition. The RN will document the Base Station physician orders on the transferring facility's patient care record. The EMT-P will document on the ePCR or O1A.

VI~~I~~. REFERENCES

Number	**Name**
5040	Radio Communication Policy
8040	Continuation of Care of a STEMI Patient (San Bernardino Only)

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.

c~~2~~. 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 Integrillin 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

a. Fort Irwin maintains internal 24-hour US Army Air Ambulance with MEDEVAC capabilities conducted by C Company (Air Ambulance), 2916th 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.

b. 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.

c. 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

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

CONTINUATION OF CARE

(San Bernardino County Only)

I. PURPOSE

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

This policy shall only be used for:

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

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

II. DEFINITIONS

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

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

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

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

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

III. INCLUSION CRITERIA

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

- Any patient with a positive STEMI requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and 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 Criteria and Destination Policy).

IV. INITIAL TREATMENT GOALS AT RH

- Initiate resuscitative measures within the capabilities of the facility.

- Ensure patient stabilization is adequate for subsequent transport.

- <u>Do not delay transport</u> by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

  - GUIDELINES

    < 30 minutes at RH (door-in/door-out).
    < 30 minutes to complete ALS continuation of care transport.
    < 30 minutes door-to-intervention at Specialty Care Center.

- RH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. Refer to Section IV - SRH-SRC Buddy System Table.

- EMS providers shall make Specialty Care Center base hospital contact.

- The Specialty Care Centers shall accept all referred trauma, stroke and STEMI patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).

- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal Trauma, STEMI, or Stroke Team according to internal TC, SRC or NSRC policies or protocols.

- RH ED physician will determine the appropriate mode of transportation for the patient.

- Simultaneously call 9-1-1 and utilize the following script to dispatch:

  "This is a Continuation of Care run from ____hospital to ____Trauma, STEMI or Stroke Center"

  Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

- RH ED physician will provide a verbal report to the ED physician at the Specialty Care Center.

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

V. SPECIAL CONSIDERATIONS

- If the patient has arrived at the RH via EMS field personnel, the RH ED physician may request that the transporting team remain and immediately transport the patient once minimal stabilization is done at the RH.

- If a suspected stroke patient is outside of the tPA administration window (greater than 4.5 hours from "last seen normal"), contact nearest stroke center to determine the best destination. Then follow the 9-1-1 script.

- EMT-Ps may only transport patients on Dopamine and Lidocaine ~~Procainamide~~ drips. Heparin and Integrillin drips are not within the EMT-P scope of practice and require a critical care transport nurse to be in attendance. Unless medically necessary, avoid using medication drips that are outside of the EMT-P scope of practice to avoid any delays in transferring of patients.

- The RH may consider sending one of its nurses or physician with the transporting ALS unit if deemed necessary due to the patient's condition or scope of practice.

- Requests for Specialty Care Transport (SCT) (ground or air ambulance) must be made directly with the EMS provider's dispatch center. The request for SCT should be made as early as possible or simultaneously upon patient's arrival so availability of resource can be determined.

- Specialty Care Center diversion is not permitted except for Internal Disaster. However, Specialty Care Center base hospitals are allowed to facilitate redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to avoid prolonged door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

VI. SPECIALTY CARE CENTER - REFERRAL HOSPITAL BUDDY SYSTEM TABLE

NEUROVASCULAR STROKE RECEIVING CENTERS (NSRC)	NEUROVASCULAR STROKE REFERRAL HOSPITALS (NSRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Colorado River Medical Center • Community Hospital of San Bernardino • Hi Desert Medical Center • St. Bernardine Medical Center • St. Mary Medical Center
Desert Regional Medical Center	• Colorado River Medical Center • Hi-Desert Medical Center
Kaiser Hospital Foundation - Fontana	• Barstow Community Hospital • Victor Valley Global Medical Center • Desert Valley Hospital
Kaiser Hospital Foundation - Ontario	• Chino Valley Medical Center • Montclair Community Hospital
Loma Linda University Medical Center	• Bear Valley Community Hospital • Community Hospital of San Bernardino • J.L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital • St. Bernardine Medical Center • Weed Army Community Hospital at Fort Irwin
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
Redlands Community Hospital	• Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital
San Antonio Regional Hospital	• Chino Valley Medical Center • Desert Valley Hospital • Montclair Hospital Medical Center • St. Mary Medical Center • Victor Valley Global Medical Center

STEMI RECEIVING CENTER (SRC)	STEMI REFERRAL HOSPITAL (SRH)
Desert Valley Hospital	• Barstow Community Hospital • Victor Valley Global Medical Center • Weed Army Community Hospital at Fort Irwin
Loma Linda University Medical Center	• Arrowhead Regional Medical Center • Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Redlands Community Hospital
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
San Antonio Regional Hospital	• Chino Valley Medical Center • Kaiser Ontario Medical Center • Montclair Hospital Medical Center
St. Bernardine Medical Center	• Colorado River Medical Center • Community Hospital of San Bernardino • Kaiser Fontana Medical Center • Mountains Community Hospital
St. Mary Medical Center	• Barstow Community Hospital • Bear Valley Community Hospital • Hi-Desert Medical Center • Robert E. Bush Naval Hospital-29 Palms • Victor Valley Global Medical Center

TRAUMA CENTER (TC)	REFERRAL HOSPITAL (SRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Chino Valley Medical Center • Desert Valley Medical Center • Kaiser Fontana • Kaiser Ontario • Mammoth Hospital • Montclair Hospital Medical Center • Northern Inyo Hospital • San Antonio Regional Hospital • Southern Inyo Hospital • St. Bernardine Medical Center
Loma Linda University Medical Center	• Bear Valley Community Hospital • Colorado River Medical Center • Hi Desert Medical Center • Mountains Community Hospital • Redlands Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Robert E. Bush Naval Hospital-29 Palms • St. Mary Medical Center • Victor Valley Global Medical Center • Weed Army Hospital
Loma Linda University Children's Hospital	• Regional Pediatric Trauma Center

VII. REFERENCES

Number	**Name**
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy
6100	Neurovascular Stroke Receiving Centers Destination Policy (San Bernardino County Only)
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)
15030	Trauma Triage Criteria

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~~Skeletal or soft tissue injuries.

3. Acute or chronic injury or disease process.

~~3~~4. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.

~~4~~5. 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 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~~initiated~~ when indicated by patient's condition.

2. Augment BLS and/or LALS assessment with ~~a~~ clinically indicated advanced assessments including but not limited to the following:

   a. ~~Qualitative lung assessment~~Cardiac monitor and/or 12-lead ECG.

   b. ~~Cardiac monitor~~Capnography.

   c. Blood glucose monitoring.

3. Augment BLS and/or LALS treatment with advanced treatments as clinically indicated ~~or available~~.

   a. Initiate airway control using an appropriate airway adjunct to achieve adequate oxygenation and ventilation.

   b. Initiate airway control only when clinically indicated for the appropriate administration of medications and/or fluids.

4. Review and evaluate treatments initiated by BLS, LALS, or ALS personnel.

   a. Consider discontinuing treatments not warranted by patient's clinical condition. Intermittent monitoring may be used instead of continuous monitoring when clinically indicated.

~~4. Initiate airway control as needed with the appropriate ALS adjunct.~~

~~5. Initiate vascular access as clinically indicated.~~

PROCEDURE - STANDARD ORDERS

12-lead Electrocardiography (EMT-P)

- ECG should be performed prior to medication administration.
- ECG should be performed on any patient whose medical history and/or presenting symptoms are consistent with acute coronary syndrome including typical or atypical chest pain, syncopal episode, prior AMI, heart disease, or other associated risk factors.

Axial Spinal Immobilization (EMT, AEMT and EMT-P)

- Should be placed if patient meets the indicators , per ICEMA Reference #15010 - Trauma - Adult (Neuro Deficits present, Spinal Tenderness present, Altered Mental status, Intoxication, or Distracting Injury).
- An AEMT and/or EMT-P may remove if placed by BLS crew and it does not meet indicators.

Continuous Positive Airway Pressure Device (CPAP) - Adult (EMT, AEMT and EMT-P)

- Start at lowest setting and increase slowly until patient experiences relief or until a maximum of 15 cm H_2O is reached.

External Jugular Vein Access (AEMT and EMT-P)

- Not indicated for patients eight (8) years of age and younger.
- Patient condition requires IV access and other peripheral venous access attempts are unsuccessful.

Intraosseous Insertion (AEMT pediatric patients only and EMT-P)

- EMT-Ps may administer Lidocaine slowly per ICEMA Reference #7040 - Medication - Standard Orders, to control infusion pain.
- Approved insertion sites:
  - Eight (8) years of age or younger (LALS and ALS):
    - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.

- Nine (9) years of age and older (ALS only):
  - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.
  - Distal Tibia - Lower end of tibia, 2 cm above the medial malleolus.
  - Humeral Head (EZ IO only).
  - Anterior distal femur, 2 cm above the patella - Base hospital contact only.

- Leave site visible and monitor for extravasation.

King Airway Device (Perilaryngeal) - Adult (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - Patients 15 years or older.
  - Anyone over four (4) feet in height.
- Additional considerations:
  - Medications may **not** be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

King Airway Device (Perilaryngeal) - Pediatric (less than 15 years of age) (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - No gag reflex.
  - Pediatric patients meeting the following criteria:
    - 35 - 45 inches or 12 - 25 kg: size 2
    - 41 - 51 inches or 25 - 35 kg: size 2.5

- Additional Considerations:
  - Medications may NOT be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

Nasogastric/Orogastric Tube (EMT-P)

- Use viscous Lidocaine gel per ICEMA Reference #7040 - Medication - Standard Orders, for conscious patients.
- Required for all full arrest patients.

Nasotracheal Intubation (EMT-P)

- Absolute contraindication: Apnea.
- Base hospital contact required: Facial trauma, anticoagulant therapy, airway burns, failed CPAP.
- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for suspected head/brain injury.
- Administer Phenylephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to place ET after a maximum of three (3) nasotracheal intubation attempts or if unable to adequately ventilate patient via BVM.

Needle Cricothyrotomy (EMT-P)

- Absolute contraindication: Transection of the distal trachea.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to ventilate adequately and transport immediately to the closest hospital for airway management.

Needle Thoracostomy (EMT-P)

- In blunt chest trauma consider bilateral tension pneumothorax if pulse oximetry (SpO_2) reading remains low with a patent airway or with poor respiratory compliance.

Oral Endotracheal Intubation - Adult (EMT-P)

- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for head injury.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- If unable to place ET after a maximum of three (3) intubation attempts (an attempt is considered made when tube passes the gum line) and, if all procedures to establish an adequate airway fail, consider Needle Cricothyrotomy.
- Document verification of tube placement (auscultation, visualization, capnography)

~~**Oral Endotracheal Intubation - Pediatric (less than 15 years of age) (EMT-P)**~~

- ~~Uncuffed tubes for patients under eight (8) years old.~~
- ~~Base hospital contact is required after two (2) failed intubation attempts (an attempt is considered made when tube passes the gum line).~~
- ~~If all procedures to establish an adequate airway fail, consider Needle Cricothyrotomy.~~
- ~~Monitor end-tidal CO_2 and wave form capnography.~~
- ~~Monitor pulse oximetry.~~
- ~~Document verification of tube placement. Run a continuous strip of capnography readings during movement of patient to verify tube placement.~~

Synchronized Cardioversion (EMT-P)

- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety.
- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.

- If rhythm deteriorates to v-fib, turn off the sync button and defibrillate.

- Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines. Procedure may be repeated at 200, 300 and 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.

- In Radio Communication Failure or with base hospital order, repeated cardioversion attempts at 360 joules or clinically equivalent biphasic energy level per manufacturer's guidelines may be attempted.

Transcutaneous Cardiac Pacing (EMT-P)

- Start at a rate of sixty (60) and adjust output to the lowest setting to maintain capture. Assess peripheral pulses and confirm correlation with paced rhythm.

- Reassess peripheral pulses. Adjust output to compensate for loss of capture.

- Increase rate **(not to exceed 100)** to maintain adequate tissue perfusion.

- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety

- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.

- Contact the base hospital if rhythm persists or for continued signs of inadequate tissue perfusion.

Vagal Maneuvers (EMT-P)

- Relative contraindications for patients with hypertension, suspected STEMI, or suspected head/brain injury.

- Reassess cardiac and hemodynamic status. Document rhythm before, during and after procedure.

- If rhythm does not covert within ten (10) seconds, follow ICEMA Reference #11050 -Tachycardias - Adult.

TACHYCARDIAS - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

IV. ALS INTERVENTIONS

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

Narrow Complex Supraventricular Tachycardia (SVT)

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

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

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

Atrial Fib/Flutter

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

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

~~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 home~~s~~.

~~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.~~

~~I~~II. 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
- Cardiotonic 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~~ Fforms 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) 882-1262 WWW.CMANET.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 cardiotonic 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.CMANET.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 cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

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.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – 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.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – 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.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – 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. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
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

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2005, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** 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.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- 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.
- 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.
- 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.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- 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.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- 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."

Section B:

- 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).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- 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.
- 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.

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 **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

- ~~**EMSA/ICEMA approved DNR medallion.**~~

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

RESPONSIVE

- Assess for ability to cry, speak or cough (e.g., “are you choking?”).
- Administer abdominal thrusts (repeated cycles of five (5) back slaps and five (5) chest thrusts for infant less than one (1) year), until the foreign body obstruction is relieved or until patient becomes unresponsive.
- After obstruction is relieved, reassess and maintain ABCs.
- Obtain ~~O_2~~-oxygen saturation on room air if possible.
- Administer oxygen.
- If responsive, place in position of comfort, enlisting help of child’s caregiver if needed. If child is uninjured but unresponsive with adequate breathing and a pulse, place in recovery position.

UNRESPONSIVE

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

- If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise or unable to ventilate, continue cycles of thirty (30) compressions to two (2) ventilations until obstruction is relieved or able to ventilate.

- If apneic and able to ventilate, provide one (1) breath every three (3) to five (5) seconds. Confirm that pulses are present and reassess every two (2) minutes.

III. LIMITED ALS (LALS) INTERVENTIONS

- If apneic and able to ventilate, consider King Airway placement per ICEMA Reference #10190 - ICEMA Approved Skills.

- If obstruction persists continue with compressions until obstruction is relieved or arrival at hospital.

- Transport to closest receiving hospital for airway management.

IV. ALS INTERVENTIONS

- ~~If apneic and able to ventilate, consider intubation per ICEMA Reference #10190 - ICEMA Approved Skills.~~

- If obstruction persists and unable to ventilate, attempt to visualize ~~with laryngoscope~~ and remove visible foreign body with Magill forceps and attempt to ventilate.

- If obstruction persists, consider Needle Cricothyrotomy per ICEMA Reference #10190 - ICEMA Approved Skills.

V. REFERENCE

Number	**Name**
10190	ICEMA Approved Skills

CARDIAC ARREST - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting. Consider the potential causes of arrest for age.

II. BLS INTERVENTIONS

- Assess patient, maintain appropriate airway; begin CPR according to current AHA Guidelines.
  - Ventilate at rate of 12 to 20 per minute. Ventilatory rate will decrease as patient age increases. Ventilatory volumes shall be the minimum necessary to cause chest rise.
  - Compression rate shall be a minimum of 100 per minute.
- If patient one (1) year of age or older, utilize AED.

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- Follow the instructions from the AED to determine if shock is ~~needed~~advised.
- Obtain IO/IV access (IO is preferred for under nine (9) years of age).
- Establish advanced airway, with minimal interruption to CPR, when resources are available~~, with minimal interruption to CPR~~.
- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
  - 1 day to 8 years: 20 ml/kg NS
  - 9 to 14 years: 300 ml NS

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

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine the cardiac rhythm and defibrillate at 2 j/kg (or manufacturer's recommended equivalent) if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IO/IV access (IO is preferred).
- ~~Establish advanced airway when resources are available, with minimal interruption to CPR.~~
- Insert NG/OG tube after advanced airway is established or if not placed with BLS airway.
- Continue CPR with compressions at a minimum of 100 /min without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.
- Utilize continuous quantitative waveform capnography, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- Initial defibrillation is administered at 2 j/kg (or manufacturer's recommended equivalent). Second defibrillation is administered at 4 j/kg. Third and subsequent defibrillation attempts should be administered at 10 j/kg not to exceed the adult dose.

- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.

- Administer Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each defibrillation unless capnography indicates possible ROSC.

- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as indicated above.

- After two (2) cycles of CPR, consider administering Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders, may repeat.

- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base hospital.

Pulseless Electrical Activity/Asystole

- Assess for reversible causes and initiate treatment.

- Continue CPR with evaluation of rhythm every two (2) minutes.

- Administer initial fluid bolus of 20 ml/kg NS for all ages, may repeat at:

  - 1 day to 8 years: 20 ml/kg NS

  - 9 to 14 years: 300 ml NS

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

Treatment Modalities for Managing Pediatric Cardiac Arrest Patient

Whenever possible, provide family members with the option of being present during the resuscitation of an infant or a child. For any termination of efforts, base hospital contact is required.

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

- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat twice for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
  - 1 day to 8 years: 20 ml/kg NS
  - 9 to 14 years: 300 ml NS
- Obtain blood glucose level. If indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
  - Naloxone for suspected opiate overdose per ICEMA Reference #7040 - Medication - Standard Orders.

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

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

V. REFERENCES

Number	Name
7040	Medications - Standard Orders
10190	ICEMA Approved Skills

SEIZURE - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

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

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

IV. ALS INTERVENTIONS

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

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

BURNS - PEDIATRIC
(Less Than 15 Years of Age)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. Manage Special Considerations

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

- **Eye Involvement**: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Airway Stabilization (as indicated). Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- IV/IO Access (warm IV fluids when available).
  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.
  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
  - < 5 years of age: IV NS 150 ml/hour
  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

- Refer to Section V - Burn Classifications below.

A. <u>Manage Special Considerations</u>

- **Respiratory Distress**:
  - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
  - Administer humidified oxygen, if available.

- **Deteriorating Vital Signs**: Transport to the closest receiving hospital. Contact base hospital.

- **Pulseness and Apneic**: Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.

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

- **Precautions and Comments**:

  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.

  - Do not apply ice or ice water directly to skin surfaces as additional injury will result.

  - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

IV. ALS INTERVENTIONS

- ~~Advanced~~ Establish advanced airway ~~(~~as clinically indicated~~)~~.

  - Airway Stabilization: Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.

  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

  - < 5 years of age: IV NS 150 ml/hour

  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Treat pain as indicated.

  - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.

- Document vital signs every five (5) minutes while medicating for pain, and reassess the patient.

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
  - Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

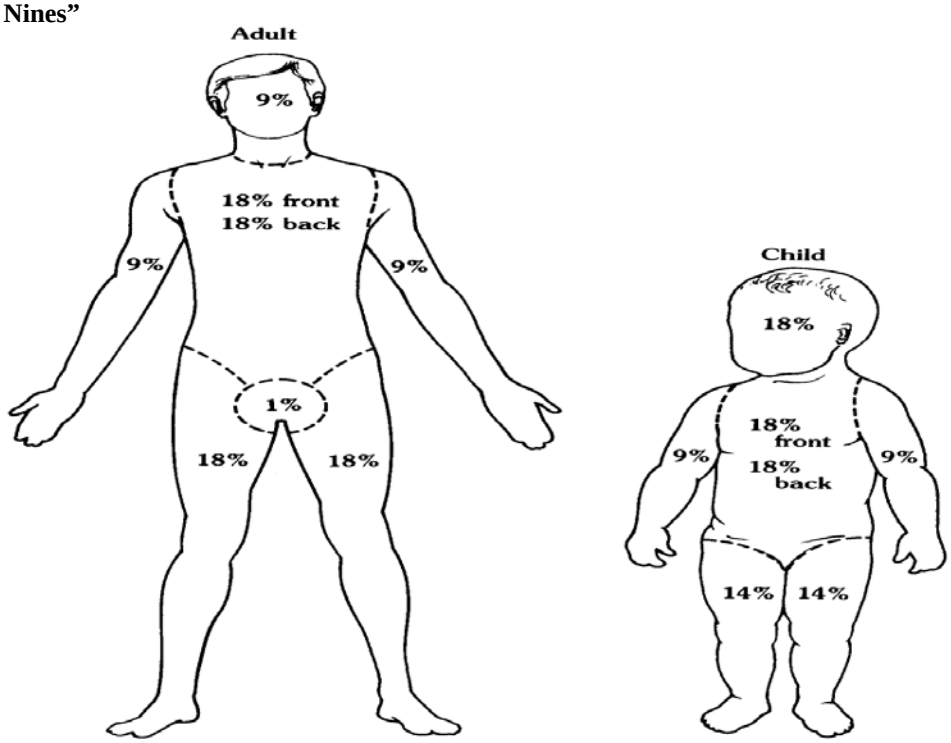
A. <u>Manage Special Considerations</u>

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

V. BURN CLASSIFICATIONS

PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
MINOR - PEDIATRIC • < 5% TBSA • < 2% Full Thickness	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MODERATE - PEDIATRIC • 5 - 10% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MAJOR - PEDIATRIC • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints	**CLOSEST MOST APPROPRIATE BURN CENTER** In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)

"Rule of Nines"



VI. REFERENCES

Number	Name
7040	Medication - Standard Orders
8130	Destination Policy
12010	Determination of Death on Scene

TRAUMA - ADULT
(15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O_2 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 axial 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 axial 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.

- **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 2nd IV access.
  - *Stable*: BP>90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

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

  Penetrating Trauma:

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

  Isolated Closed Head Injury:

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

- Transport to appropriate hospital.

A. <u>Manage Special Considerations</u>

- **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 axial 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.

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

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

- *Severe Blunt Force Trauma Arrest*: If indicated, transport to the closest receiving hospital.
- *Penetrating Trauma Arrest*: If indicated, transport to the closest receiving hospital.
- If the patient does not meet the "Obvious Death Criteria" in ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- **Precautions and Comments**:

  - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.

  - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

  - If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.

  - **Unsafe scene may warrant transport despite low potential for survival.**

  - Whenever possible, consider minimal disturbance of a potential crime scene.

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

IV. ALS INTERVENTIONS

- Advanced Airway (as indicated):

  - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #8120 - Continuation of Care.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* BP <90mmHG and/or signs of inadequate perfusion, start 2nd IV access.

  - *Stable*: BP >90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

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

  - *Stable*: IV NS TKO

Penetrating Trauma:

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

Isolated Closed Head Injury:

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

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

A. <u>Manage Special Considerations</u>

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

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

  - Consider maintaining spinal alignment on the gurney, or using axial 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.

- **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

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