INYO COUNTY

EMERGENCY MEDICAL CARE COMMITTEE

LONE PINE FIRE DEPARTMENT
131 N. Jackson St.
Lone Pine, CA
93546

January 24, 2011
QI Committee --5:00 p.m.
EMCC -- 6:00 p.m.

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF NOVEMBER 1, 2010 MINUTES **ACTION**

III. ICEMA UPDATE **INFO/ACTION**

IV. EMS SYSTEM MANAGEMENT REPORTS **INFO/ACTION**

A. Base Hospital Report
B. Scantron/ePCR Report

V. OLD BUSINESS **INFO/ACTION**

A. EMS Strategy Subcommittee Report
B. EMT Education
   1. Maddy Funds; any interest in redistributing the 17%
   2. Other funding sources for EMT education
C. EMS Debriefing Program
D. Other

VI. NEW BUSINESS **INFO/ACTION**

A. EMCC Membership for 2011-2012
B. MCI Plan
C. California Public Health and Medical Emergency Operations Plan
   (Available at www.bepreparedcalifornia.ca.gov - public comment period ends Feb 4th)
C. EMS Provider of the Year
D. EMS Radio System
E. QI Plan
G. Protocols
   1. Reference # 1050 MICN Certification Requirements
   2. Reference # 1080 Flight Nurse Authorization
   3. Reference # 3020 Continuing Education Provider Requirements
   4. Reference # 3030 EMT Continuing Education Requirements
   5. Reference # 5040 Radio Communication Policy
   6. Reference # 6020 EMT AED Service Provider Policy
   7. Reference # 6090 Fireline Paramedic
   8. Reference # 10160 Axial Spinal Stabilization

9. Reference # 11040 Bradycardias - Adult

VII. OTHER/PUBLIC COMMENT

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

IX. NEXT MEETING DATE AND LOCATION

X. ADJOURNMENT

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

INYO COUNTY EMCC MEETING
OWENS VALLEY UNIFIED SCHOOL DISTRICT, CAFETERIA BUILDING
Hosted by:
Independence Volunteer Fire Department
MINUTES
November 1, 2010

Voting Members Present:

Andrew Stevens	Northern Inyo Hospital	Andrew.stevens@nih.org
Dr. Michael Dillon	ER Physician	MichaelDillon@qnet.com
Jean Turner	Health & Human Services, Director	jturner@inyocounty.us
Joe Cappello	Independence Fire Department	jcappello@cebridge.net
Judd Symons, Vice Chair	Symons Emergency Specialties, Inc.	juddsymons@aol.com
Le Roy Kritz	Lone Pine Fire Department, Chief	LChief2401@lonepinetv.com
Lee Barron	Southern Inyo Hospital	leebee40@aol.com
Lloyd Wilson	Big Pine Fire Department	dlwilson41@msn.com
Mike Patterson	Sierra Life Flight, Program Director	mike@sierraaviation.com
Paul Postle, Chairperson	So. Inyo Fire Prot. District, Chief	paul2701@wildblue.net
Phil Ashworth	Independence Fire Department	philinyo@usamedia.tv
Steven Davis	Olancha Cartago Fire Dept., Chief	olanchafire@aol.com

Voting Members Absent:

Martha Reynolds	Northern Inyo Hospital	marthareynolds@nih.org

Other Attendees:

Gina Ellis	ICHHS, Recording Secretary	gellis@inyocounty.us
Ray G. Seguine	Bishop Fire Department	Seguine@ca-bishop.us
John Marzano	Big Pine Fire Department	BigPineFire@chilitech.net
Denise Lauffer	Southern Inyo Hospital	dlauffer@sihd.org
Fred Hawkins	Liberty Ambulance	
Dr. Rick Johnson	Inyo County Public Health	drrickjohn@gmail.com
Tamara Cohn	Inyo County Public Health	tcohn@inyocounty.us
Melissa Best-Baker	Inyo County Public Health	mbestbaker@inyocounty.us
Lisa Erwin	Northern Inyo Hospital	Lisa.Erwin@NIH.org
Virginia Hastings	ICEMA	vhastings@cao.sbcounty.gov
Chris Yoshida-McMath	ICEMA	c.yoshida-mcmath@cao.sbcounty.gov
Sherri Shimshy	ICEMA	sshimshy@cao.sbcounty.gov
John Mueller	ICEMA	jmueller@cao.sbcounty.gov
Paul Easterling	ICEMA	peasterly@cao.sbcounty.gov
Reza Vaezazizi, MD	ICEMA	rvaezazizi@cao.sbcounty.gov
Denice Stiles	ICEMA	dwicker-stiles@cao.sbcounty.gov

I. CALL TO ORDER

Chairperson, Paul Postle called the meeting to order at 6:18 p.m.

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II. APPROVAL OF JULY 19, 2010 MINUTES

Motion Leroy Kritz, seconded by Steve Davis to approve the minutes of the July 19, 2010 EMCC meeting. There was no opposition to the motion; motion carried.

III. ICEMA UPDATE

A. Medication Shortage Update

Dr. Vaezazizi spoke about ongoing medication shortages. He listed the medications, and stated that the shortages are temporary. There have not been shortages at the local level.

B. STEMI

Dr. Vaezazizi reported on STEMI programs, and a recent training he attended saying that the starting point is collecting data, and reporting that data to local Q.I. committees.

C. Stroke Center Update

Dr. Vaezazizi gave an update on Stroke Centers, saying that ICEMA is expecting four (4) San Bernardino County Hospitals to apply for designation. He gave a background on the studies that have been conducted. He added that ICEMA is monitoring the situation, but that it may be over a year away for Inyo and Mono Counties, and that there are challenges such as rapidly identifying patients.

D. MCI Reviews

ICEMA recently reviewed a Mass Casualty Incident (MCI) that occurred in Inyo County on August 9, 2010. A presentation was given on what ICEMA does with the information that they receive for local providers. The report identified areas for improvement and successes as well as number counts for victims and responding units. Dr. Vaezazizi complimented local responders on how the incidents were handled saying that local providers may be under rating themselves with how they are handling patient care, adding that rural healthcare can do a lot. It was questioned why an EMS debriefing was not done. Northern Inyo Hospital did a hot wash about two (2) days after the incident. ICEMA may want to take the lead on the MCI debrief, and organize it in the future. When questioned if there is an MCI plan for Inyo County, Dr. Rick Johnson reported that he, along with others, have been working on the policy, which is in draft form. It must be approved by ICEMA. Virginia Hastings spoke about ReddiNet and how it could have been useful in this situation. Incident debriefing was also conducted by the Inyo County Mental Health Department. There was group discussion on services offered to responders. Bishop Fire Chief, Ray Seguine, expressed concern that the responders, first responders and hospital staff were invited to a meeting with a counseling team

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from San Bernardino to talk about issues and responder's feelings, but not how the incident was handled. This was a lesson learned; perhaps a protocol and process can be developed.

It was suggested that a smaller group be established to create a protocol and definitions, and that it could be incorporated as part of the MCI plan. It was suggested that each of the Fire Chiefs make it a point to check with their responders who may need help. Every provider should have its own plan to follow up with its own personnel, and that it's up to the provider. This item will be added to the next agenda for follow up.

IV. EMS SYSTEM MANAGEMENT REPORTS

A. ALS/BLS Reports

The ALS/BLS Scantron reports for the period of January-September 2010 were distributed, and it was noted that the information would also be posted on the ICEMA website.

B. Base Hospital Report

The Base Hospital Report was distributed, and will be posted on the ICEMA website.

C. ePCR Update

It was reported that all providers were trained and everything is operating. It is the EMS personnel's responsibility to enter their data. The next software change will be going to RFP, and will most likely result in a new vendor. There was discussion on the vendor, and the non-renewal. The RFP is in draft form. The most challenging change is getting people to go from paper to electronic.

III. OLD BUSINESS

A. EMS Strategy Subcommittee Report

Steve Davis reported that the EMS Strategy Subcommittee has met a total of three (3) times. He stated that a lot of short-term strategies have been covered, and that long-term strategies require more time and money. He spoke about a recent workshop with the Inyo County Board of Supervisors in an effort to inform them of the struggles local EMS providers are experiencing. As a result of a recent accelerated EMT course which was partly paid for with MADDY funds, he reported that twenty-two (22) students graduated, four (4) tested, and two (2) passed the test. He spoke about a FEMA grant called SAFER, recruitment and retention. The grant was written, and all County providers are participating. He is hopeful that he will hear back on the grant towards the end of January or early February. He spoke

about the DMV Driver Exemption as another accomplishment of the subcommittee. Health and Human Services (HHS) Director, Jean Turner, commended Steve Davis on his leadership of the subcommittee, adding that the grant could be very helpful for at least the next four (4) years. She reported that another BOS workshop will be held on November 9, 2010 at 1:30 pm in Independence. There was discussion on EMT education and whether there was any interest in redistributing the seventeen percent (17%) of MADDY Funds for EMT education. Currently, the funds go to the volunteer ambulance providers if they choose to submit proposals that must meet the funding parameters. Historically, MADDY funds are applied to equipment purchases by individual providers. It was suggested that perhaps some, but not all, of the money be used for education. HHS will put together a trend report on expenditures. This item will be added to the next agenda to be revisited. Chairperson Paul Postle added that the subcommittee will continue to meet at the pleasure of the EMCC when there is an issue.

B. Other

None

IV. NEW BUSINESS

A. EMCC Membership for 2011-2012

Jean Turner informed the group that recruitment will soon open to fill EMCC membership slots that will expire on December 31, 2010. Membership applications were distributed to those in attendance who were interested in membership. Members will be appointed by the Board of Supervisors in December.

B. National EMS Scope of Practice Model

It was reported that Supervisory Fortney was going to speak about the National EMS Scope of Practice Model that was included in the meeting packet. He is interested in the four (4) levels that are outlined. He was thinking that the Emergency Medical Responder could be a starting point. Virginia Hastings distributed a handout titled "Inyo/Mono Counties State Required EMS Course Hours" which included costs. She noted that the information was from the State regulations. The group was asked to review. Ms. Hastings stated ICEMA has an infrastructure for the various levels. The potential for using the Emergency Medical Responder level as a bridge to the Emergency Medical Technician level was discussed. The program currently does not exist so would need to be researched. ICEMA would have to go back to the state. Steve Davis discussed the A-EMT and his view of the use of the levels locally.

C. EMT Education

1. Maddy Funds; any interest in redistributing the 17%

This topic was discussed earlier in the meeting, and will be revisited at the next meeting.

2. **Other funding sources for EMT education**
   This topic was discussed earlier in the meeting.

D. Debriefing program for emergency workers involved in major accidents, shootings, suicide, etc.

This topic was discussed earlier in the meeting, and will be revisited at the next meeting.

V. OTHER/PUBLIC COMMENT

VI. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

A. Debriefing program for emergency workers involved in major accidents, shootings, suicide, etc

B. Maddy Funds - Redistributing the 17%

VII. NEXT MEETING DATE AND LOCATION

Monday, January 24, 2010, Lone Pine Volunteer Fire Department
Q.I. 5:00 p.m.
EMCC 6:00 p.m.

VIII. ADJOURNMENT

Motion Andrew Stevens, seconded by Lloyd Wilson to adjourn the meeting. There was no opposition to the motion, motion carried. The meeting adjourned at 8:15 p.m.

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In the Rooms of the Board of Supervisors

County of Inyo, State of California

I, HEREBY CERTIFY, that at a meeting of the Board of Supervisor of the County of Inyo, State of California, held in their rooms at the County Administrative Center in Independence on the 4th day of ***January,*** 2011 an order was duly made and entered as follows:

HHS-Hlth. Serv./ EMCC Appointments	Moved by Supervisor Arcularius and seconded by Supervisor Cervantes to appoint the following to the Emergency Medical Care Committee (EMCC) to complete two-year terms ending December 31, 2012, Lee Barron of Southern Inyo Hospital, Joe Capello of Independence Volunteer Fire Department, Michael Dillon of Northern Inyo Hospital, LeRoy Kritz of Lone Pine Fire Department, Paul Postle of Southern Inyo Fire Protection District, and Richard Johnson of Inyo County Public Health. Motion carried unanimously.

WITNESS my hand and the seal of said Board this 4th

Day of ***January*** ***2010***

By: *Patricia Gunsolley,Assistant*

Routing

CC
Purchasing
Personnel
Auditor
CAO
Other HHS – Committee Book
Appointees
DATE: January 17, 2011

Inyo County
Emergency Medical Care Committee

MEMBER	AGENCY	E-MAIL ADDRESS	TERM EXPIRES
Ashworth, Phil	Independence Volunteer Fire Department	philninyo@usamedia.tv	12/31/11
Barron, Lee	Southern Inyo Hospital	Leebee40@aol.com	12/31/12
Cappello, Joe	Independence Volunteer Fire Department	jcappello@cebridge.net	12/31/12
Davis, Steven	Olancha Cartago Fire Department	olanchafd@aol.com	12/31/11
Dillon, Michael	Northern Inyo Hospital	dillon@qnet.com	12/31/12
Johnson, Richard	Health and Human Services	drrickjohn@gmail.com	12/31/12
Kritz, LeRoy	Lone Pine Fire Department	LChief2401@lonepinetv.com	12/31/12
Patterson, Mike	Sierra Life Flight	mike@sierraaviation.com	12/31/11
Postle, Paul	Southern Inyo Fire Protection District	Paul2701@wildblue.net	12/31/12
Reynolds, Martha	Northern Inyo Hospital	marthareynolds@nih.org	12/31/11
Stevens, Andrew	Northern Inyo Hospital	andrew.stevens@nih.org	12/31/11
Symons, Judd	Symons Emergency Services	juddsymons@aol.com	12/31/11
Wilson, Lloyd	Big Pine Fire Department	dlwilson41@msn.com	12/31/11

MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT in Mono and Inyo Counties

PURPOSE

1. To outline and coordinate the responses by EMS system participants to Multi-Casualty Incidents (MCI) in Mono and Inyo Counties.

2. To standardize definitions, as outlined in the Firescope Field Operations Guide (FOG) and the responsibilities of each participating entity.

PRINCIPLES

1. Field responses to an MCI will follow the procedures/guidelines consistent with the Incident Command System (ICS) as outlined in Firescope.

2. Hospitals shall receive as much advanced notice as possible to prepare for arriving patients.

SCOPE

An MCI is any incident where personnel (law, fire, or medical) on scene have requested additional resources to care for all victims. This may include one or more of the following criteria:

- An incident requiring three or more ambulances and/or involving five or more patients
- The utilization of triage (e.g. START) tags
- Patient distribution beyond one hospital

PROCEDURE

General Operational Procedures:

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource shall remain in command until relieved by the public safety agency having jurisdictional authority.

2. Sheriff's Office (SO) Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions) OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.

3. The first medical personnel (e.g. ambulance crew) on scene shall:
   - Become the Medical Group Supervisor, and
   - Initiate triage. Adults shall be triaged according to START as outlined in Firescope. Pediatric patients shall be triaged according to JumpSTART developed by California Emergency Medical Services for Children. Triage and patient tracking and coordination with receiving hospitals shall be accomplished utilizing standard triage tags.
   - Assume responsibility for requesting additional resources (e.g. ambulances, personnel, equipment) in coordination with the base hospital, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and available and relevant (dependent on geographical location and availability and communications capability), and
   - Assume responsibility for patient tracking and matching patient types/needs with appropriate and available transportation resources and staff and receiving hospitals, in coordination with the base hospital, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), and
   - Contact base hospital and/or receiving hospitals and/or EMS aircraft providers for patient destination and coordination once the MCI has been declared.

4. All operation functions and procedures on scene will be in accordance with Firescope and National Incident Management System (NIMS).

5. The Medical Group Supervisor shall establish communications with the base hospital and/or receiving hospitals through available methods for situation update (i.e. Medical Sit Rep) and to obtain hospital bed availability/ coordination, with the assistance and support of SO and/or CHP Dispatch, EMS aircraft providers, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and relevant (dependent on geographical location and availability and communications capability).

6. The Medical Group Supervisor will identify and request the necessary resources through the IC or designee. The IC or Medical Group Supervisor will contact the base hospital and/or receiving hospitals and/or OES Mutual Aid Coordinators (fire, law, MHOAC), with the assistance and support of SO and/or CHP Dispatch, as available and appropriate, to fulfill medical resource requests.

7. During incidents with multiple destination hospitals, the Medical Group Supervisor may assign a Medical Communications Coordinator (Med Comm). The Med Comm will provide the following information when initially communicating with Dispatch (SO or CHP), the base hospital and/or receiving hospitals, or OES Mutual Aid Coordinators (fire, law, MHOAC):

   - Name of incident, type, location, initial patient estimate and agency in charge.
   - Patients should be transported to the appropriate hospitals as provided to the Med Comm by the Medical Group Supervisor.

8. The Medical Group Supervisor, shall notify the base hospital and the receiving hospital(s) (or Med Comm shall notify Dispatch, if available and assigned, to relay to the hospitals) (or EMS aircraft providers shall communicate with receiving hospitals)of the following information for all patients departing the scene:

- Transport method (e.g. air, ground, bus)
- Transport agency and unit
- Number of patients (adult and pediatric)
- Identification (triage tag number) and classification of patients (i.e. Immediate, Delayed, Minor)
- Destination (only when Med Comm is coordinating multiple hospital destinations based on base hospital, EMS aircraft providers, and/or Medical Group Supervisor evaluation of hospital availability)

9. Transporting units shall make attempts by available means to contact the receiving hospital en route to provide patient(s) report using the incident name to identify the patient and provide the following information:

- Incident name
- Transporting name and unit number
- Age/sex
- Illness or mechanism of injury
- Triage classification (immediate (red), delayed (yellow), green (minor)), and any significant deterioration in condition/status during transport
- Chief complaint and related illness/injury that may need specialty services, (e.g. respiratory, neuro, vascular, decontamination, burns)
- Glasgow Coma Scale (GCS), if relevant
- Estimated Time of Arrival (ETA)
- Tracking of patients and destinations is the primary joint responsibility of the base hospital and field medical personnel, with assistance as requested and available from the Dispatch.

If the destination is changed en route, the transporting unit shall notify the initial receiving hospital, if possible, and shall make attempts to contact the new receiving hospital en route. If the base hospital is coordinating patient destinations in conjunction with the Med Comm, the transporting unit will notify the base hospital, who will notify the original destination that the patient has been diverted by the base hospital physician or that the patient condition has deteriorated.

Special Operational Procedures - Use of Non-Emergency Vehicles:

The Medical Group Supervisor, in coordination with the IC, may utilize non-emergency vehicles to transport patients triaged as Minor (green). The Medical Group Supervisor (or Med Comm, if assigned) will coordinate the destinations with the base hospital and/or receiving hospitals, if there are multiple receiving facilities. In such cases, the following conditions shall apply:

1. Non-emergency vehicles may be requested through the IC, through Dispatch or by special arrangement made on scene by the Medical Group Supervisor.

2. If resources allow, at least one ALS team (minimum of one paramedic and one EMT-1) with appropriate equipment will accompany each non-emergency transport vehicle. Generally, the ratio of patients to ALS team should not exceed 15:1.

3. When resources do not permit an ALS team to accompany a non-emergency transport vehicle, a BLS team consisting of at least two EMT-1's and/or First Responders will accompany the vehicle. Generally, the ratio of patients to BLS team should not exceed 9:1.

4. In the event of deterioration of a patient en route, the non-emergency unit shall immediately call for an ALS emergency ambulance, if available, and transfer care for transport to the closest emergency department.

Responsibilities of Dispatch:

1. SO Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions), and County OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.

2. SO Dispatch shall assist, collaborate, and help to coordinate the filling of resource requests from the base hospital, IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as available. This may include mutual aid resources from outside the operational area, including ground and/or air transportation resources and personnel.

Responsibilities of the Base Hospital:

1. Upon field notification of an MCI, the base hospital shall immediately notify area hospitals. If there is the potential for multiple patient destinations, the base hospital will poll area hospitals for bed availability.

2. The base hospital shall assist, collaborate, and help to coordinate the filling of all resource requests from the IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as requested This may include mutual aid medical resources from outside the operational area.

3. The base hospital shall coordinate with Dispatch, the IC, the Medical Group Supervisor or designee, and the OES Mutual Aid Coordinators, the deployment of all air resources for the MCI, as requested.

4. The base hospital shall notify ICEMA and the MHOAC when three or more ambulances are requested for an incident.

5. If the base hospital is coordinating patient destinations, it will confirm patient departure from scene with Med Comm, if assigned, by providing the departure time and estimated time of arrival (ETA) to the receiving hospital.

6. The base hospital will advise receiving hospitals of the number/categories of patients en route via approved method (e.g. radio, telephone).

7. If the base hospital needs additional resources, it shall contact the MHOAC.

Responsibilities of the Receiving Hospital:

1. All hospitals shall respond immediately to any request from the Medical Group Supervisor or designee for bed availability.

2. A receiving facility may not change the destination of a patient.

3. If the receiving facility needs additional resources, it shall contact the MHOAC.

4. Each hospital that received patients from the MCI shall participate in after action reports and improvement plans as necessary.

Responsibilities of the OES Mutual Aid Coordinators (fire, law, MHOAC):

1. The Medical Health Operational Area Coordinator (MHOAC) Program is comprised of the personnel, facilities, and supporting entities that fulfill the functions of the MHOAC role as directed by the MHOAC. The MHOAC is a functional designation within the Operational Area, filled by the Health Officer and the local emergency medical services agency administrator (or designee/s), that shall assist the other Operational Area Coordinators (fire, law) in the coordination of situational information and medical and health mutual aid during emergencies.

2. The MHOAC Program is the principal point-of-contact within the Operational Area for information related to the public health and medical impact of an emergency. Within two hours of incident recognition, it is expected that the MHOAC Program will prepare and submit the electronic Health and Medical Situation Report to the activated local emergency management agency (Duty Officer, IC/UC, EOC), to the RDMHC/S Program (REOC), to CDPH, and to EMSA (Duty Officers or JEOC if activated).

3. The Mutual Aid Coordinators (fire, law, MHOAC) are responsible for coordinating the process of requesting, obtaining, staging, tracking, using, and demobilizing mutual aid resources. If Unified Command has been established for an incident, health and medical entities request resources through the Operations and Logistics Section of field-level Unified Command, which coordinates the resource fulfillment within the Operational Area, or from neighboring Operational Areas where there are cooperative assistance agreements or day-to-day relationships in existence.

4. If the resource cannot be obtained locally, the MHOAC Program will request health and medical resources from outside of the Operational Area by working with the RDMHC/S Program in preparing and submitting a Health and Medical Resource Request Form to the activated local emergency management agency (Duty Officer, IC/UC, EOC) and to the RDMHC/S Program (REOC). Examples include, but are not limited to, additional transportation resources (ambulance strike teams, EMS aircraft), accepting specialty facility beds/physicians (multi-trauma, burns, pediatrics), and ventilators.

Medical Control:

1. EMS personnel shall operate within ICEMA "prior to contact" protocols for both medical and trauma patients.

2. When base hospital consultation occurs, medical control refers to a specific patient and not to the incident as a whole (operational aspects).

3. When multiple hospital destinations exist, medical control has the option of referring the resource establishing radio contact to the base hospital for bed availability.

Field Documentation:

1. The Medical Group Supervisor (or Med Comm, if established) maintains responsibility to ensure the following:

   a) Utilization of the approved ICEMA/MCI patient care report. This form will include:

      1. Name and location of the incident
      2. Triage tag number for each patient and the hospital destination
      3. Brief description of the incident

   b) Completion of an individual patient care report for each deceased individual at the incident.

c) Completion of an individual patient care report for all patients with a chief complaint and who "refuse treatment." As feasible, ask patients to sign a release of liability (e.g. Against Medical Advice (AMA) liability form).

2. Each transporting unit is responsible for generating a patient care report for each patient transported excluding patients transported by non-emergency vehicles. Those transported in non-emergency vehicles will be identified by triage tags. This should include patient tracking tag/number and will indicate the incident name and location.

ADDENDUM

Firescope Operations Procedures of a Multi-Casualty Incident

Operational System Description

The Multi-Casualty Organizational Module within the Firescope Field Operations Guide (ICS 420-1) is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor who reports in most cases to the IC, or the Multi-Casualty Branch Director, if activated. Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The Medical Branch structure in the ICS system is designed to provide the IC with a basic, expandable modular system for managing the incident. The system is designed to be set up consistent in all incidents involving mass casualties and has the ability to expand the incident organization as needed.

Initial Response Organization: Initial response resources are managed by the IC, who will handle all Command and General Staff responsibilities. The resources will respond based on the **operational procedures** (as outlined in this protocol).

Reinforced Response Organization: In addition to the initial response, the Medical Group Supervisor may establish a Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, Medical Communications Coordinator (Med Comm), and Ambulance Coordinator. Also patient treatment areas are established, if needed.

Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch may be designated to provide coordination between the Ambulance Coordinator and the Air Operations Branch. The Extrication Group is established to free entrapped victims.

Multi-Branch Incident Organization: The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals. If necessary for span of control, the IC may appoint a Medical Branch Director to oversee the Medical Group and other relevant groups.

Operational Principles

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource will remain in command until relieved by the public safety agency having jurisdictional authority.

2. The IC will assign the first available resource to triage. Victims shall be triaged according to START/JumpSTART criteria, and ICS shall be implemented according to Firescope and NIMS.

3. The IC will assign the resource with the appropriate communications capability to establish communications with the base hospital for resource requests, as needed.

4. Treatment areas are set up based upon needs and available resources according to classification of patients (Immediate, Delayed and Minor.) The Treatment Unit Leader will notify Patient Transportation Unit Leader when a patient is ready for transportation and of any special needs (e.g. burns, pediatrics, decontamination). If these positions are not assigned, the Medical Group Supervisor will retain this responsibility.

5. Patients are transported to the appropriate facility based upon patient condition, bed availability, and transport resources. The Medical Group Supervisor is responsible for patient transportation and destination and may assign/delegate this responsibility to a Patient Transportation Unit Leader and a Medical Communications Coordinator who would work together to transport the patients using the appropriate methods to the most appropriate destinations.

6. The Patient Transportation Unit Leader and Med Comm, if assigned, will determine all patient destinations in coordination with the base hospital.

7. The IC will designate a staging area(s). Transportation personnel should stay with their vehicles to facilitate rapid transport, unless reassigned by the IC or designee.

8. The Patient Transportation Unit Leader will then call for an ambulance or other designated transportation vehicle to respond to the loading area.

9. The Patient Transportation Unit Leader, in coordination with the IC, may put in a request through Dispatch for buses to transport minor or uninjured patients.

10. The Patient Transportation Unit Leader will copy the information from the triage tag onto a Patient Transportation Log, and confirm destination with the ambulance crew, bus, or other driver.

11. The Patient Transportation Unit Leader will notify the Med Comm, if assigned, of patient departure.

12. The transporting unit should contact the receiving facility en route with a patient report, using the incident name to identify the patient.

ICEMA

Quality Improvement Plan

DRAFT
9/30/2010

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INTRODUCTION

In 1991, the California Emergency Medical Services Authority (EMSA) promulgated legislation which mandated that local Emergency Medical Services (EMS) agencies establish a system-wide quality assurance program. This legislation requires Advanced Life Support (ALS) service providers and base stations to develop and implement a quality assurance program approved by Inland County Emergency Medical Agency (ICEMA).

On January 1, 2006, EMSA implemented regulations related to quality improvement for EMS throughout the State. ICEMA's Continuous Quality Improvement Program (CQIP) satisfies the requirements of Title 22, Chapter 12, Section 4 of the California Code of Regulations.

Continuous Quality Improvement (CQI) is an ongoing process in which all levels of health care are encouraged to team together, without fear of management repercussion, to develop and enhance the EMS system. Based on EMS community collaboration and a shared commitment to excellence, CQI reveals potential areas for improvement of the EMS system, training opportunities, highlights outstanding clinical performance, audits compliance of treatment protocols and allows the review of specific illnesses or injuries and their associated treatments. This program contributes to the continued success of our emergency medical services system through a systematic process of review, analysis and improvement.

CQI implements the principles of quality improvement by defining standards, monitoring the standards and evaluating their effectiveness. It places increased emphasis on the processes of care and service rather than on the performance of individuals. It also emphasizes the role of leadership in continuous quality improvement rather than only on solving identified problems and maintaining improvement over time.

The by-product of the program is the alliance of municipal agencies and private providers that offer EMS within the ICEMA region. This provides all participants the opportunity to provide optimal service and to provide input and support to an EMS system in which they have ownership.

The ICEMA CQIP has been written in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines #166 (Rev. 03/04).

PURPOSE

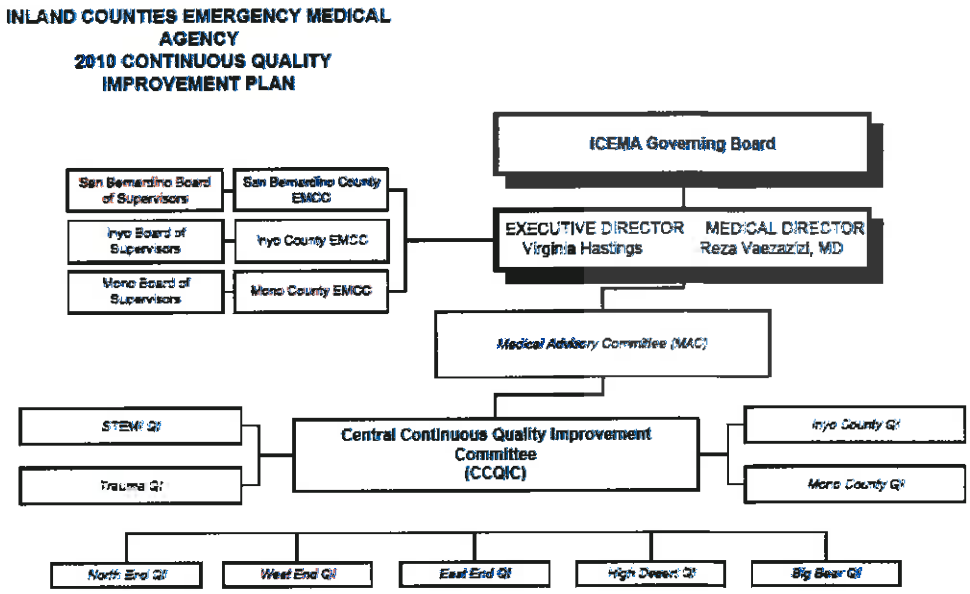
The purpose of the ICEMA CQIP is to establish a system-wide process and provide an effective tool for evaluating and improving the quality of prehospital care within the ICEMA region. This tool will focus on improvement efforts to identify root causes of problems and interventions to eliminate or reduce those problems. While striving to improve the system, the CQIP will also recognize excellence in performance and service to the stakeholders.

SECTION I - STRUCTURE & ORGANIZATIONAL DESCRIPTION

I. ORGANIZATION

ICEMA is a three county Emergency Medical Services Agency serving the counties of San Bernardino, Inyo, and Mono counties. The three counties largely provide advanced life support and basic life support services.

A. Organizational Chart



B. Mission Statements

ICEMA

ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective EMS system including prehospital providers and specialty care hospitals.

CQI

The CQI mission is to promote the highest level of quality in prehospital care within the ICEMA region by providing CQI, education, monitoring tools and anticipatory planning.

C. Goals of the Continuous Quality Improvement Program

1. Empower EMS providers to provide consistently the highest quality of emergency medical care in the ICEMA region.

2. Provide leadership and guidance in promoting quality in the local EMS system with the cooperation of EMS providers in an educational and non-punitive environment.

3. Develop leadership to create an acceptance and belief in quality improvement and educate provider management regarding the importance of the commitment to quality improvement.

4. Provide leadership in developing programs that implement the CQI process by providing examples of high quality training and educational resources.

5. Develop and provide an atmosphere of encouragement and support that promotes excellence and personal accountability to provider personnel in all levels of management and field staff.

6. Create constancy in the CQI process to maximize efficiency and effectiveness in each EMS provider organization.

7. Promote rapid and appropriate quality treatment of all patients regardless of economic or social status in the quickest and most efficient manner possible.

8. Evaluate the benefits of new programs and procedures to provide "State of the Art" health care within the ICEMA region.

9. Provide a conduit for communication between EMS providers and other agencies to positively resolve issues in addition to providing education and encouraging growth within the EMS system.

II. STRUCTURE

A. ICEMA CQI Team

1. ICEMA is responsible for the oversight and implementation of the regional CQIP, data collection and evaluation of the EMS system in the region.

2. ICEMA CQI Team will function with direction and under the auspices of the Medical Director and Executive Director. This team shall include an educational coordinator, QI Coordinator, data analyst, ICEMA Medical Director and Executive Director.

B. ICEMA's Duties

Shall include but not be limited to:

1. Serve as the central repository of data gathered from CQI activities.

2. Provide an annual review of the CQIP for compatibility to the system and update, if needed.

3. Facilitate a performance improvement action plan with the cooperation of the appropriate EMS providers when the CQIP recognizes a need for improvement. EMS system clinical issues will require ICEMA Medical Director involvement.

4. Provide information to EMS provider advisory groups to assist in the development of performance improvement plans.

5. Work in conjunction with the EMSA to:

   - Participate in the EMSA Technical Advisory Group.
   - Assist with the responsibilities of the state-wide CQIP.
   - Assist in development, approval and implementation of State required and optional EMS system indicators.

6. Provide monitoring, data collection, reporting and evaluation of EMS system indicators from EMS providers and hospitals in the ICEMA region.

7. Identify and develop specific indicators for system evaluation based on the unique needs of the ICEMA region.

8. Annually review, expand on and improve State and local EMS system indicators as needed.

9. Provide opportunities for review of QI indicators and performance improvement plans by designated EMS providers.

10. Provide technical assistance, training and in-service education to all organizations participating in the ICEMA CQIP.

11. Provide an annual summary of activity and CQIP implementation. The summary will be provided annually to the EMSA and should include but not limited to a summary of QI indicators.

C. Description of Committees

1. Medical Advisory Committee

The Medical Advisory Committee (MAC) will function under the direction of the ICEMA Medical Director. The ICEMA Medical Director shall serve as chair and may appoint an alternate chair in his absence. The members shall have education and experience in EMS systems and regional prehospital care. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- Base Station Physician
  - Trauma Base Physicians (2 representatives)
  - Non Trauma Base Physicians (2 representatives)
- Non Base Station Physician
- Public Transport Medical Director
- Private Transport Medical Director
- Fire Department Medical Director
- Ambulance Association Representative
- EMS Nurses Representative
- EMS Officers Representative
- Inyo County Representative
- Mono County Representative

2. Central Continuous Quality Improvement Committee

The Central Continuous Quality Improvement Committee (CCQIC) will function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in evaluation of EMS data systems and EMS QI program management. The members will participate in monitoring and evaluating the CQIP. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
  - CQI Program Coordinator

  - Educational Coordinator
  - Data Program Coordinator
- Regional Continuous QI Committee Members (7, one from each committee)
- EMS Service Provider Medical Director (2)
  (one public and one private provider representative)
- Base Station Medical Director (2)
  (one Trauma Center and one non-Trauma Center)
- EMS Provider QI Program Coordinator (2)
  (one public and one private provider representative)
- Paramedic Training Program Representative (2)
  - Crafton Community College
  - Victor Valley Community College
- Base Station Nurse Coordinator (2)
  (one Trauma Center Paramedic Liaison Nurse (PLN) and one non-Trauma Center PLN)
- Nurse from a non-base STEMI Center
- Representatives from 9-1-1 receiving facilities emergency department representatives (2)
  (Non Base Station)
- EMT and EMT-P Representative
  Certified/licensed personnel accredited within ICEMA (2)
  (one public and one private provider representative)

3. Regional Continuous Quality Improvement Committees

Due to the size of the ICEMA region, QI Committees are regionalized under the umbrella of the CCQIC. The Regional CQI Committees (RCQIC) function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in the evaluation of EMS data system and CQIP management. The members will participate in monitoring the process as it unfolds within the system. These committees meet monthly. The members shall be multidisciplinary and include the following established committees:

- West End CQI Committee
- East End CQI Committee
- North End CQI Committee
- Big Bear CQI Committee
- Hi Desert CQI Committee (Joshua Tree/29 Palms)
- Inyo County CQI Committee
- Mono County CQI Committee

4. STEMI CQI Committee

The STEMI CQI Committee (STCQIC) functions under the direction of the ICEMA Medical Director and Executive Director. The members will have education and experience in the evaluation of Cardiovascular QI program management. The members will participate in ongoing monitoring and evaluation of the ICEMA STEMI program as it unfolds in the system. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
  - STEMI CQIP Coordinator
  - Educational Coordinator
  - Data Program Coordinator
- STEMI Center Medical Director(s)
  (One from each facility either ED Director or Cath Lab Director, or their designee)
- Base Station Medical Director (2)
  (one STEMI center and one non-STEMI center)
- EMS Provider CQI Program Coordinator (2)
  (one public and one private provider representative)
- Base Station Nurse Coordinator (2)
  (one STEMI center PLN and one non-STEMI center PLN)
- Representatives from local receiving facilities emergency department physicians (2)
  (Non STEMI center)
- Representative Advanced Life Support (ALS) Providers
  Certified/licensed personnel accredited within ICEMA (2)
  (one public and one private provider representative)
- Cath Lab Nursing Directors or designee

5. Trauma System Advisory Committee

The Trauma System Advisory Committee (TSAC) monitors trauma related care and system related issues, including air utilization. TSAC also serves as the prehospital and hospital medical care and system advisory committee. This committee meets quarterly.

TSAC functions under the direction of the ICEMA Medical Director and Executive Director. TSAC members will have education and experience in the management and evaluation of the Trauma QIP. The members will participate in ongoing monitoring and evaluation of the Trauma QIP. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director

- ICEMA Representative(s)
  - Trauma Coordinator
  - Educational Coordinator
  - Data Program Coordinator
- Trauma Center Medical Director(s)
  (one from each trauma center)
- Pediatric Trauma Attending(s)
  (one from each trauma center)
- Base Station Medical Director (2)
  (one from a trauma center and one from a non-trauma center)
- Non-Trauma Center Emergency Department Physicians
  (with an interest in trauma care)
- Trauma Center Coordinator (2)
  - ARMC
  - LLUMC (Adult)
  - LLUMC (Pediatric)
- Trauma Center PLNs
  (one from each trauma center)
- EMS CQI Program Coordinators
- Prehospital Personnel
  - Fire Chief's Association Representative
  - Ambulance Representative
  - Air Rescue Representative
  - Coroner or Representative

6. Trauma and Air Audit Committee

ICEMA participates in a joint San Bernardino County and Riverside County Quality Improvement committee called Trauma and Air Audit Committee (TAAC). TAAC is a closed, regional QI committee addressing multi-county system and medical issues. This committee meets quarterly. The TAAC committee is comprised of representatives from both San Bernardino and Riverside Counties:

- Riverside EMS Agency Representatives
- ICEMA Representatives
- Medical Directors (ED/Trauma and non-trauma hospital)
- Nurse Managers (ED/Trauma and non-trauma hospital)
- Trauma Hospital Paramedic Liaison Nurses (PLNs)

D. Term of Committee Memberships

Term of Membership shall be two (2) years expiring December 31 and subsequent new terms shall begin January 1. The terms shall be staggered so that no more than two-thirds of the membership shall expire in any one-year period. A member whose term has expired shall continue to serve until a new appointment is confirmed. Members may be reappointed.

E. Attendance

1. Members will notify ICEMA in advance of any scheduled meeting they will be unable to attend.

2. At the discretion of ICEMA, other individuals may participate in the meetings when their expertise is essential to make appropriate determinations.

3. The absence of a committee member from two (2) consecutive meetings of the committee shall be cause for the Chairman to contact the committee member to discuss participation in the meetings. Whenever a committee member fails to attend two (2) consecutive meetings or three (3) total meetings in a calendar year, without good cause, the Chairman shall discuss with the committee and recommend the members removal from the committee.

4. Resignation from the committees must be submitted, in writing, to ICEMA, and is effective upon receipt, unless otherwise specified.

F. Chairperson

The ICEMA Medical Director shall serve as chair of the CCQIC. Other committees will allow nominations and voting for a Chairperson and a Co-Chairperson. The term of elected members will be for two (2) years.

G. Voting

Due to the advisory nature of these committees, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Chairperson. When voting is required, a simple majority of the members present will constitute a quorum. The chair will break any tie vote.

H. Alternate Members

Alternate members may serve as a representative of an appointed member in the event that an appointed member is unable to attend scheduled meetings due to conflict in scheduling and/or illness. The appointed member must designate in writing the alternate member to serve in his/her absence. The written notice must be submitted to and approved by ICEMA at least five (5) working days prior to a scheduled meeting. Alternate members shall not be utilized on a regular basis.

I. Minutes

Minutes will be kept by a designee from ICEMA and distributed to the members prior to each meeting. Due to the potential need for confidentiality, certain documents may be collected by the ICEMA staff at the close of each meeting and no copies may be made or processed by members of the committee without written consent from ICEMA.

J. Responsibilities

1. If a representative is unable to attend a meeting, he or she is responsible to appoint an alternate for attendance and representation as mentioned above under "Alternate Members".

2. Disseminate non-confidential information, as appropriate, and discuss at meetings to the represented groups.

3. Determine indicators for system evaluation based on EMS QI indicators and identify and develop other indicators as deemed necessary.

4. Re-evaluate and improve locally developed EMS system indicators annually or as needed.

5. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement CQIP templates.

6. Recommend the chartering of RCIQCs and review of their reports.

7. Seek and maintain relationships with all EMS participants including, but not limited to:

   - State EMSA
   - Other Local EMS Agencies (LEMSAs)
   - EMS Service Providers
   - Local Departments of Public Health
   - Specialty Care Centers
   - Law Enforcement
   - Public Safety Answering Points (PSAPs)
   - Dispatch Centers
   - Constituent Groups

K. Confidentiality

All proceedings, documents and discussion of the committees are confidential and are covered under Sections 1040, 1157.5, and 1157.7 of the Evidence Code of the State of California. The prohibition relating to the discovery of testimony provided to the committees shall be applicable to all proceedings and records of this group, which is established by a local government agency as a professional standards review organization. This organization is designed in a manner which makes available professional competence to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to prehospital care services. Guests may be invited to discuss specific issues in order to assist in making final determinations. Guests may only be present for the portion (s) of the meeting about which they have been requested to review or testify.

All members shall sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through committee membership. Prior to the invited guests participating in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement for invited guests.

III. PARAMEDIC BASE STATION REQUIREMENTS

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The Base Station CQIP should involve all EMS system participants including, but not limited to dispatch agencies, ALS and BLS service providers, receiving hospitals and specialty care hospitals.

1. Structure

The Base Station CQIP shall be reviewed by ICEMA for compatibility with the State CQIP guidelines. The organizational chart should reflect the integration of the CQIP in the organization.

Listed below are minimum requirements of Base Station CQIP:

a. A CQI Team under the direction of the Base Station Medical Director. Lead staff should have expertise in management of the Base Station's CQIP. The following staffing positions are identified (note: organizations with limited resources may combine positions):

- Base Station Medical Director (or designee)
- EMS QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural facilities. It is understood that there are variances in staffing and staff responsibilities.

b. An internal CQIP Technical Advisory Group with members, which include but are not limited to:

- Base Station Medical Director
- Prehospital Liaison or Equivalent
- Base Station Mobile Intensive Care Nurse (MICN)

2. Responsibilities

The Base Station CQI Team should be a primary source of EMS activity reporting for state-wide and regional EMS system indicators. The Base Station CQIP will perform the following functions:

a. Cooperate with ICEMA in carrying out the responsibilities of the ICEMA CQIP and participate in the ICEMA CQI process.

b. Cooperate with ICEMA in the implementation of State required EMS system indicators.

c. Cooperate with ICEMA in monitoring, collecting data, and evaluating State required and ICEMA EMS system indicators.

d. Cooperate with the EMSA and ICEMA in the re-evaluation and improvement of State and local EMS system indicators.

e. Participate in meetings for internal review of Base Station indicators and development of performance improvement programs related to the findings.

f. Establish a mechanism to incorporate input from ICEMA, service providers and other hospitals for the development of performance improvement programs.

g. Assure reasonable availability of CQIP training and in-service education for Base Station personnel.

h. Prepare plans for expanding or improving the Base Station CQIP.

i. Provide technical assistance to all EMS provider's CQIPs in the Base Station's jurisdiction.

3. Annual Reports

Base Stations must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

B. REVIEW OF PATIENT CARE DATA

1. Mobile Intensive Care Nurse Report

A minimum of 30 (or the total if <30) randomly selected MICN reports with waveforms, or 10%, whichever is greater, will be reviewed monthly by the PLN and/or Base Station Medical Director, or designated peer review staff, for the following:

a. Complete documentation.
b. Prehospital patient care treatment orders.
c. Compliance with ICEMA protocols.

2. Base Station Wave Reviews

All waves that fall into the following categories must be reviewed for determination of cause and must be logged and included in the quarterly report submitted to ICEMA:

a. A case review request is submitted.
b. Any call where a physician has ordered an EMT-P to administer a medication or perform a skill that is out of his scope of practice, or in deviation with protocol.
c. Runs involving internal disaster or trauma diversion.
d. High profile cases.

3. Concurrent/Retrospective Clinical Review Report

The CCQIC may select a clinical topic on a quarterly basis to be audited by the Base Stations and provider agencies. Examples are cardiac arrest, head trauma and respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen, utilizing data obtained from electronic patient care records (e-PCRs). Examples may include timely administration of ACLS medications, documentation of responses to the administration of medications and/or procedures. This report will be forwarded to ICEMA and may be used to determine recommendations to the ICEMA Medical Director regarding the appropriateness of certain drugs, equipment, procedures, etc., for improvement in the delivery of quality patient care in the EMS system.

4. Base Station Statistics

Base Stations are required to keep on-going statistics for periodic review by the EMS agency staff. Requirements for documentation in this log are included in the Base Station Statistics Policy and Base Station Data Collection Tool. Monthly reports shall be submitted as required by ICEMA.

5. Case Review Reports

A confidential file of case review reports will be maintained by the PLN and/or Base Station Medical Director. Documentation should include the case review report and any other pertinent data. The case review report is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors without prior written notification. See QI Form 008, 009 and 010.

The laws protecting the discoverability of information received through the quality assurance process state very clearly that information must be maintained in a confidential manner. Breaches that result in loss of the confidentiality of these records allow the information to be accessible to

discoverability and seriously jeopardize the quality assurance/quality improvement process. All case review records must be kept in a confidential file and maintained to protect all parties involved.

6. Radio Communication Failure Reports

The Base Station Medical Director or PLN will be required to report any radio equipment failures to ICEMA within 72 working hours. See QI Form 001.

7. Quarterly Reports

Quarterly reports must include all relevant information and be forwarded to ICEMA at the first of every quarter (the first of January, April, July and October). Requirements for these reports are illustrated in the Quarterly Report Form. See QI Form 007.

IV. EMERGENCY MEDICAL SERVICE PROVIDER

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The EMS Provider's CQIP should involve EMS system participants including but not limited to dispatch agencies, ICEMA, training programs, hospitals, specialty care centers and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended.

CQIP's should include indicators, covering the areas listed in the California Code of Regulations, Title 22, Chapter 12 of the Emergency Medical Services System Quality Improvement Program, which address, but are not limited to, the following:

- Personnel
- Equipment and Supplies
- Documentation and Communication
- Clinical Care and Patient Outcome
- Skills Maintenance/Competency
- Transportation/Facilities
- Public Education and Prevention
- Risk Management

Indicators should be tracked and trended to determine compliance with their established thresholds as well as reviewed for potential issues. Indicators should be reviewed for appropriateness on a quarterly basis with an annual summary of the indicators performance. Air Medical Providers may reference CAMTS to identify potential indicators they may wish to implement in their system.

ALS Provider agencies must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

1. Structure

The EMS Provider's CQIP shall be reviewed and approved by ICEMA for compatibility with the guidelines.

The organizational chart shall reflect the integration of the CQIP in the organization. The EMS Provider's CQIP should include the following:

a. An EMS CQI Team under the direction of the EMS Provider's Medical Director or EMS Administrator. Lead staff should have

expertise in management of the EMS provider's CQIP. The following staffing positions are identified:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural agencies. It is understood that there are variances in staffing and staff responsibilities (organizations with limited resources may combine positions).

b. An internal CQI Technical Advisory Group with members including, but not limited to:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- Chief/EMS Administrator or designee.
- QI Program Coordinator.
- Service Personnel (Physicians, RNs, Paramedics, EMTs).
- Other system participants.

2. Responsibilities

The EMS Provider's CQIC should be the primary source of CQIP activity reporting for state-wide and local EMS system information. The EMS Provider's CQIC will perform the following functions:

a. Cooperate with ICEMA in carrying out the responsibilities of ICEMA's CQIP and participate in ICEMA's CCQIC.

b. Cooperate with ICEMA in the implementation of State required EMS system indicators.

c. Cooperate with ICEMA in monitoring, collecting data, and evaluating the State and regional/local EMS system indicators, both required and optional.

d. Cooperate in the re-evaluation and improvement of State and local EMS system indicators.

e. Conduct meetings for internal review of EMS provider information and development of performance improvement programs related to the findings.

f. Establish a mechanism to receive input from ICEMA, other service providers and other EMS system participants for the development of performance improvement programs.

g. Assure routinely scheduled CQIP training and in-service education for EMS provider personnel.

h. Prepare plans for expanding or improving the EMS Provider's CQIP.

i. Participate in meetings and presentations of state and local EMS system information for peer review to local designated advisory groups and other authorized constituents.

3. Annual Reports

The EMS Provider's CQI Team will annually publish summary reports of CQIP activity for distribution to ICEMA and other groups as determined.

B. ALS STAFFING REQUIREMENTS AND RESPONSIBILITIES

1. ALS Provider Agency Medical Director Guidelines

Shall be a physician licensed in the State of California with experience in emergency medical care. Must be knowledgeable of the policies, protocols, and procedures set forth by ICEMA.

2. ALS Provider Agency Medical Director Responsibilities

a. Demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader for the organization, providing educational opportunities, training, support and encouraging communication of skills to facilitate the team building network.

b. Shall be responsible for coordinating and implementing an approved provider agency CQIP that focuses on the opportunity for improvement as well as identification and prevention of potential concerns within the organization, implements resolutions to these problems and evaluates the outcome, as well as provides the positive recognition when an opportunity is provided.

c. Shall provide a written operational protocol manual for approval by ICEMA (applies only to Air Transport Teams utilizing flight nurses in the EMS region).

3. ALS Provider Agency Quality Improvement Coordinator Requirements

Each ALS provider agency shall have a CQI Coordinator. This person shall be either: 1) a physician, registered nurse or physician assistant that is licensed in California and has experience in emergency medicine and emergency medical services or 2) a paramedic who is or has been licensed in California within the last two (2) years and who has at least two (2) years experience in prehospital care.

4. ALS Provider Agency Quality Improvement Coordinator Responsibilities

a. Shall act as a liaison between the prehospital personnel and the Base Station Medical Director, PLN, ED physician, other provider agencies and ICEMA.

b. Shall initiate, implement and evaluate the agency's quality improvement program.

c. Shall be responsible for monitoring documentation of program operations within the agency, as required for evaluation by ICEMA.

d. Shall monitor EMS personnel compliance to policies, procedures and protocols and ability to function within the scope of practice.

e. Shall demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader when providing training and educational opportunities, encouragement, support and communication skills to promote an EMS system that delivers the best available patient care.

f. Shall participate in their regional CQI committees and Base Station CQI process.

C. REVIEW OF PATIENT CARE DATA

1. ALS Run Report Forms

A minimum of thirty (or the total if <30) randomly selected ALS runs, or 10 %, whichever is greater, must be reviewed each month by the CQI Coordinator or by the designated peer review staff for at least the following:

a. Complete documentation.
b. Ordering of prehospital patient care treatment.
c. Compliance with protocols.

d. Response times and prolonged on-scene times
e. E.T. attempts and placement.
f. MCI as defined by Protocol Ref. #5050, Multi-Incident Operational Procedures (review with Paramedic PLM).
g. Proper documentation of Against Medical Advice (AMA) forms (review with PLN).

2. Concurrent and Retrospective Clinical Review Topics

The ICEMA Regional CQIC may select a clinical topic on a quarterly basis to be audited by the Base Station and ALS Provider agencies; examples; cardiac arrest patients, patients with head trauma, respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen (utilizing data obtained from e-PCRs). Examples of this may include: timely administration of ACLS drugs, documentation of responses to the administration of medications and/or procedures. These reports will be forwarded by the Base Station to the committee and may be used to determine recommendations to the ICEMA Medical Director.

3. ALS Provider Agency Log

ALS Provider agencies will be required to keep an on-going log for periodic review by ICEMA. Requirements for documentation in this log are spelled out in the Quality Improvement Log Form. See QI Form 005.

A confidential file of case review reports will be maintained by the Provider Agency CQI Coordinator and/or ALS Provider Agency Medical Director in accordance with specifications under CASE REVIEW FORMS, Section IV. Documentation should include the case review report and any pertinent data. This is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors.

V. CASE REVIEW FORMS/CASE REVIEW CONFERENCE

A. INITIATING A CASE REVIEW

To request that a call be reviewed, a Case Review Form must be initiated, and forwarded to the QI Coordinator, ALS Provider Agency Medical Director, PLN or Base Station Medical Director. The report should be forwarded to the person responsible for reviewing the incident within the agency or facility. For example, if an EMT-P initiates a report, EMT-P should forward it to the agency QI Coordinator for review. If an MICN initiates a report, MICN should forward the report to the PLN. See QI Form 008.

A Case Review Form may be initiated by any physician, MICN, EMT-P, or EMT, who feels that any of the following have occurred:

- Treatment/action resulting in positive patient outcome.
- Patient care related to an adverse patient outcome.
- Deviation from ICEMA treatment protocols.
- Conflicts with existing State law and/or ICEMA policy.
- Situations that pose a threat to the safety of patients or providers of prehospital care.
- Situations that serve as an educational tool for EMS providers.

When the request involves the QI Coordinator, PLN or Medical Director normally responsible for the initiation of the case review form, the request should be forwarded to ICEMA.

If there is any doubt as to who is the responsible reviewing party, ICEMA will provide direction.

B. CONDUCTING A CASE REVIEW

Upon receipt of a Case Review Form, the person responsible for the investigation shall:

- Review the EMS patient care record, MICN record, Base Station wave, and the patient outcome records (if applicable).
- Collect statements from the involved personnel if needed to determine action necessary.
- Establish the need for further action.
- Involve the appropriate agency representatives (i.e., ALS Provider Agency QI Coordinator should contact the PLN and Base Station Medical Director if determination of further action is necessary).
- Conduct a Case Review Conference, if necessary. See QI Form 010.

C. CONDUCTING A CASE REVIEW CONFERENCE

1. Responsible Reviewing Party

The responsible reviewing party shall notify the appropriate personnel and determine a time and date that the Base Station Medical Director, PLN and all involved personnel can attend the Case Review Conference (CRC). A CRC must be done within thirty (30) days of the decision to conduct a CRC unless it meets the exception criteria.

Exception Criteria:

a. Involved personnel could not be contacted (written explanation required in summary).
b. Documents needed for review could not be gathered in this time frame (explanation must be included in summary).

2. Review of Information

The Case Review Conference will require a review of all information necessitating the conference and any additional information that may be pertinent to the review. The Medical Director is responsible for determining the need for further action. The Medical Director may make the determination that the incident requires one of the following:

a. Positive Recognition:

A CRC may be held to evaluate outstanding performance to be utilized for positive education feedback. An evaluation and recommendations report shall be forwarded to the ICEMA Medical Director.

b. No Further Action Necessary:

Complete a Case Review Conference Report stating the conclusion of the investigation and forward a copy of the report to the ICEMA Medical Director. Maintain the original document in the Case Review Report File.

c. Need For Education:

The Base Station Medical Director shall determine if the need for education is related to an individual or is of an educational value to the EMS system, or both.

d. EMS System Education:

The review has led to the opportunity to provide educational value to benefit the system (i.e., a piece of equipment has proven to be defective when used in certain environments). A Case Review Conference Report shall be completed and a copy forwarded to the ICEMA Medical Director. Maintain the original report in the Case Review Report File. Suggestions for system-wide improvements will be submitted to ICEMA CCQIC and the EMCC, and addressed through education.

3. Plan of Action

The determination has been made that an individual or individuals would benefit from the initiation of the education process.

a. Identify the Area of Improvement - i.e., skills deficiency, lack of working knowledge of ICEMA protocols, etc.

b. Recommend a Plan of Action - For example, the Base Station or ALS provider agency may be requested to provide skills training, further monitoring, protocol updates, etc. In this circumstance, the ICEMA Medical Director will request follow-up in writing from the ALS provider agency and will determine the period in which this is to be provided. Complete the Case Review Conference Report (QI Form 008) providing the appropriate information and forward a copy to the ICEMA Medical Director upon completion of the conference. Maintain the original Case Review Conference Report in the Case Review Report File.

c. Initiate the Plan of Action - Provide the education, monitoring, etc., as determined by ICEMA Medical Director.

d. Evaluation of the Outcome - The ICEMA Medical Director will evaluate the outcome of the process, the need to re-evaluate at a future date if necessary or to provide further education. This information should be included in follow-up form on a Case Review Conference Report and a copy submitted to the ICEMA Medical Director. Maintain the original report in the Case Review Report File.

4. Disciplinary Action Needed

The need for disciplinary action should only be initiated if ICEMA's Medical Director determines the situation reflects grounds for disciplinary action under Chapters 4 and 6 of the California Code of Regulations (CCR), Title 22. All pertinent information should then be forwarded immediately to the ICEMA Medical Director for consideration of further action.

SECTION II - DATA COLLECTION AND REPORTING

Data collection and reporting are two of the most important elements in CQI. The data collected must be valid, reliable, and standardized with all other system participants. ICEMA encourages the sharing of data through summary reports among all EMS system participants.

This chart provides suggested indicators for each Indicator category per organizational structure. Use of these indicators is not mandatory.

Assumptions: 1. California EMS Information System (CEMSIS) will provide state-wide data.

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Personnel	WELLNESS WORKLOAD POLICIES AND PROCEDURES LICENSURE ED1 Education and Training Indicator A - H	WELLNESS WORKLOAD POLICIES AND PROCEDURES CERTIFICATION /ACCREDITATION ED1 Education and Training Indicator A - D, G, H	WELLNESS WORKLOAD POLICIES AND PROCEDURES ED1 Education and Training Indicator A, B (if provider has EMT-I training school)	WELLNESS WORKLOAD POLICIES AND PROCEDURES BH1 Base ~~Hospitals~~Stations-Activity Indicator B - D
Equipment and Supplies	ePCR INVENTORY CONTROL	COMMUNICATIONS COVERAGE	PREVENTIVE MAINTENANCE PLANS PHARMACEUTICALS	INVENTORY CONTROL
Documentation		DATA VALIDATION ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	DATA VALIDATION NARCOTIC RECORDS ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	TIMELINESS ACCURACY OUTCOME REPORTING QUALITY REVIEW PROCESSES
Clinical Care and Patient Outcome	SCOPE OF PRACTICE COMMITTEE STRUCTURE RESEARCH CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - B	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach -Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J MA1 ALS Staffing Levels Indicator A - D RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B, N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B, N CA3 Chest Pain-Suspected Cardiac Origin Indicator J RE1 Shortness of Breath Bronchospasm Indicator G RE2 Shortness of Breath Fluid Overload Indicator K

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Skills Maintenance Competency	SCOPE OF PRACTICE	SCOPE OF PRACTICE SKILLS UTILIZATION BENCHMARKING SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES (BENCHMARKING) SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES
Public Education and Prevention	COMMUNITY INVOLVEMENT PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1A Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B
Risk Management	ISSUE RESOLUTION PROCESS SYSTEM MONITORING	ISSUE RESOLUTION PROCESS SYSTEM MONITORING CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B MA1 ALS Staffing Levels Indicator A - D	ISSUE RESOLUTION PROCESS OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONNEL SAFETY SYSTEM MONITORING MA1 ALS Staffing Levels Indicator A - D RS1 Response Indicator A - C SK1 Skills – Advanced Provider Indicator A - J	OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONAL SAFETY SYSTEM MONITORING

SECTION III - EVALUATION OF INDICATORS

The ICEMA QI Coordinator will analyze the quality indicators on a monthly basis and then create relevant reports for presentation to the MAC and/or EMCC.

SECTION IV - ACTION TO IMPROVE

I. FOCUS-PDSA

Once a need for improvement in performance has been identified by ICEMA, MAC or the EMCC, ICEMA will be utilizing the FOCUS-PDSA model for performance improvement. FOCUS-PDSA involves the following steps:

Find a process to improve - the CCQIC will identify improvement needs.

Organize a team that knows the process - the CQI Team will form Task Force(s) as needed and review process documents.

Clarify current knowledge of the process - review indicator trends relevant to the process, collect other information

Understand - causes of process variation utilizing tools, such as fishbone diagrams, Pareto analyses, etc.

Select - process improvement to reduce or eliminate cause(s).

Plan - State objective of the test, make predictions, develop plan to carry out the test (who, what where, when).

Do - Carry out the test, document problems and unexpected observations, begin analysis of the data.

Study - Complete the analysis of the data, compare the test data to predictions, and summarize what was learned.

Act - What changes are to be institutionalized?
What will be the objective of the next cycle?
What, if any, re-education or training is needed to effect the changes?

Once a Performance Improvement Plan has been implemented, the results of the improvement plan will be measured. Changes to the system will be standardized and/or integrated. A plan for monitoring future activities will be established.

II. MEETINGS

During its quarterly or other meetings, ICEMA or MAC may identify indicators that signal a need for improvement and make recommendations for chartering a Quality Task Force, if needed. ICEMA or the CCQIC may select members and charter a Task Force with a specific objective for improvement. Each Task Force will use the FOCUS-PDSA model to conduct improvement planning and prepare recommendations or a report for review by ICEMA. ICEMA will prepare a report including the findings and recommendations of the Task Force and make recommendations to the Task Force and prepare the report for distribution to the MAC. ICEMA will also disband the Quality Task Force at the appropriate time.

Presentation of quality indicator analyses will most frequently be in a run chart, a Pareto chart, or a histogram format. This will enable ICEMA and/or MAC to easily identify trends and to rapidly interpret the data.

ICEMA, CCQIC and MAC will meet at least quarterly to evaluate and discuss the data provided by the ICEMA QI Coordinator according to the following agenda:

- Review of prior meeting action items.

- Presentation of indicators and results/trends.

  For each indicator that the CCQIC reviews, the following process will be followed:

  - Identify the objectives of the evaluation.
  - Present indicators and related EMS information.
  - Compare performance with goals or benchmarks.
  - Discuss performance with peers/colleague.s
  - Determine whether improvement or further evaluation is required.
  - Establish plan based upon decision.
  - Assign responsibility for post-decision action plan.

- Examine correlations between/among trends.

- Acknowledgement of positive trends; discussion of unsatisfactory trends.

- Receive reports from Quality Task Forces, if any.

- Discuss changes needed to indicators.

- Recommend the chartering of Quality Task Forces, if any.

- Provide input to ICEMA to regarding improvement priorities.

- Summarize action items identified at this meeting.

- Recommend training/educational needs.
- Evaluation of the meeting.

SECTION V - TRAINING AND EDUCATION

Once the decision to take action or to solve a problem has occurred, training and education are critical components that need to be addressed. Education needs will be identified in reports given at quarterly MAC and CCQIC meetings. The EMS Agency will make recommendations for educational offerings county-wide based on these reports and reports from CQI Task Forces.

Once a Performance Improvement Plan recommended by a Task Force, the ICEMA QI Team, or MAC has been implemented, ICEMA will standardize the changes within the appropriate policies and procedures. The EMS Specialist responsible for educational oversight maintains the Policy and Procedure Manual, which is updated twice per year. Changes recommended by a Quality Task Force or other system participants are implemented via policy changes or new policies being written as indicated. The new policy or change in policy is presented at the various EMCCs for discussion. Changes may be made based on those discussions. The policy is then posted on the ICEMA website at www.ICEMA.net for a 45-day public comment period. Final changes to the policy are made based on public comments received. The new or improved policy is then implemented. If additional training is required of system participants, time is allotted for that training prior to the implementation of the policy. Policies also may be changed to comply with State or Federal mandates. These changes are written into the policies and are discussed at various committee meetings and the EMCCs and posted on the ICEMA website, but do not go out for a public comment period.

The EMS Specialist who is responsible for educational oversight also ensures that providers submit documentation that all training requirements have been met by all EMS system participants, usually twice per year and on an as-needed basis. This is accomplished via training memos, training program development, or by train-the-trainer programs. Providers are ultimately responsible for ensuring that staff is adequately trained. The rosters and records of training are available to ICEMA upon request.

SECTION VI - ANNUAL UPDATE

The Annual Update is a written account of the progress of an organization's activities as stated in the EMS CQIP. An EMS Specialist is responsible for annually updating the EMS Plan, in alignment with current EMS strategic goals. The CQI Coordinator will do an initial review of the CQIP, identifying what did and did not work. The CQI Coordinator will work in conjunction with the EMS Specialist responsible for updating the EMS Plan to ensure that both the CQIP and the EMS Plan are focusing on the same objectives. Once both the CQIP and the EMS Plan have been reviewed in this fashion, the CQI Coordinator will present his/her findings to the CCQIC and to the CQI Team.

The following chart will be the template for the presentation of the update.

Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan/Plans for Further Action	Were Goals Met? Is Follow-up Needed?

As part of the Annual Update, the ICEMA CQI Team and the CCQIC will offer recommendations for changes needed in the CQIP for the coming year, including priority improvement goals/objectives, indicators monitored, improvement plans, how well goals/objectives were met, and whether follow-up is needed.

A current CQIP will be submitted to the State EMS Authority every five (5) years.

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
1000 ACCREDITATION AND CERTIFICATION		
1050	MICN	Clarification of the language for certification and the education requirements
1080	Flight Nurse Authorization Requirements	Clarification of the language for certification and the education requirements and removal of testing requirements
2000 DATA COLLECTION		
NONE		
3000 EDUCATION		
3020	Continuing Education Requirements	The order of the definitions have been changed. Formating changes.
3030	EMT Continuing Education Requirements	Change in format of protocol and clarification of requirements. Change of education requirements to mandatory sixteen (16) hours of medical based CE's and eight (8) hours of other.
4000 QUALITY IMPROVEMENT		
4010	Continous Quality Improvement Plan	New document
5000 MISCELLANEOUS SYSTEM POLICIES		
5040	Radion Communication Plan	Complete rewrite to simplify and clarify radio communictions between base stations and EMS providers.
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
6020	EMT AED Service Provider	Delete policy out dated and redundent
6090	Fireline Paramedic	Change from emergency protocol to permanent protocol
7000 STANDARD DRUG & EQUIPMENT LISTS		
7010		
7020		
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
8010	Interfacility Transfer Guidelines	Changed to Monitor thoracostomy tubes to water or dry sealed dranage
9000 GENERAL PATIENT CARE POLICIES		
NONE		
10000 SKILLS		
10160	Axial Spinal Stabilization	Change of format and clarification of the protocol
11000 ADULT EMERGENCIES		
11040	Bradycardia	Correction of typographical error.
12000 END OF LIFE CARE		
NONE		
13000 ENVIRONMENTAL EMERGENCIES		
NONE		
14000 PEDIATRIC EMERGENCIES		
NONE		
15000 TRAUMA		
NONE		
POLICY DELETIONS		

Below are some of the protocols/policies designated for review in the next few months. If there are specific protocols/policies recommended for review, please contact ICEMA

March 1, 2011 Protocol Manual Changes

Policy #	Title	Changes/Comments
NONE		

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

Protocol Reference #'s 1050 and 1080

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Both	Redlands Fire	Good	
1050	Rancho Cucamonga FD	On Page 3, #5 – I presume this is regarding certs. Issued for short periods of time to match RN license, but it is confusing when you read it. Could use an intro line to clarify.	No change
1050	RFCD	On page 6, #e. "an additional 6 hours of field care audit. I assume this is because they are not answering the radio. Most of these RNs review many tapes for audits, QA, QI. Is it possible to read "6 hours of reviewing tapes of calls" or something of that sort instead of official field care audits? Many tapes are reviewed for many reasons but may be by themselves. It would be nice to get credit for those and not have to attend an additional 6 hours of official FCA	As long as the review is properly documented on a roster or review form it may count towards the audits. There has to be a tracking mechanism.
1080	RCFD	No comments	
1050	SACH	1) Grammatical consistency: Pg 1 of 6, 5. a and b: should state "candidate who fails ....must pay..." as in other similar sections. The same for Pg. 5 of 6, 6.a	We will make grammar consistent
		2) Grammar on pg. 3 of 6, 2.h should state "Continuous certification applicants not meeting the above requirement must pay..."	We will make grammar consistent
		3) Pg. 2 of 6, 5.b: request reduction of remedial training from eight (8) to four (4) hours given by the PLN/Medical Director. Rationale: extremely tight time and budget constraints.	No change

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		All else looks good to me. VS	
1080	SACH	Looks good to me; defer to flight nurses and their providers. VS	
1050	Barstow Fire	No changes needed	
1080	Barstow Fire	No Changes needed	
1050	San Manuel FD	Agree with policy as it is	
1080	San Manuel FD	1. I believe PALS should be added to the requirements. It demonstrated the standard of care. 2. Many organizations require advanced certifications for their flight crews. I believe ICEMA should require the CFRN for all our flight nurses. Providing Critical care in the flight environment is demanding. There are many proven standards that we should uphold in our region. The CFRN requirement is a good way to ensure our patients receive the standard of care.	This will be referred back to Protocol Review and Medical Advisory committees for proper consideration and recommendation.
1050	Ontario Fire	On Page 3 under Number 5 – Is this section referring to individuals whose certification has lapsed? If so, can this be clarified? It is confusing.	This refers to initial certification.
1080	Ontario Fire	No Comment	

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

Protocol Reference # 3020 and 3030

PROTOCOL #	AGENCY	COMMENT	RESPONSE
3020	Redlands Fire	Good	
3030	Redlands Fire	Under "Continuing Education" 1L. If there is only one instructor, does there need to be a separate CE roster for one person?	Yes and it must be clearly marked Instructor
3030	Redlands Fire	Under "Continuing Education" 1M it states "Credit will be given, one time only, for each specific course, during a certification/licensure cycle," but in 1L it states" Credit will be given, one time only, for each specific course, during a certification/licensure cycle." Therefore, you can only get half the credit if you are an instructor. It would seem the person whom takes the time to master a subject should receive at least the same credit.	No change Consistent with state regulations
3020	Rancho Cucamonga FD	No comments	
3030	RCFD	Page 3 #L – For Instructor Credit – the separate roster – would that be the standard ICEMA Roster with the same class info with the addition of "Instructor(s)". Wouldn't it be easier to just give the person(s) listed at the top as instructor's credit vs. creating duplicate rosters and adding the word "instructor"? They are required to be listed at the top of the roster currently. The separate list/roster seems like additional paper and possible confusion.	No change
3020	SACH	Minimal change so noted; no comments. VS	

PROTOCOL #	AGENCY	COMMENT	RESPONSE
3030	SACH	I approve all changes; well written and reflects ICEMA's advocacy for continuing education.	
3020	Barstow Fire	Instructor Maybe you could add and instructor 1A or 1B or equivalent teaching class	No change
3030	Barstow Fire	Good no changes needed	
3020	San Manuel FD	1. We should waive the requirement of a copy of the license for our physician lectures. We invite Physicians to teach because they are on the cutting edge of medical care. They will not usually have a copy of their license readily available. They may even be conducting the class remotely and in real time. We want to provide as many Physician taught CE hours as possible. The copy of the license seems a bit excessive.	No change This is part of a physician CV and credentials are an important part of validating a speaker
3030	San Manuel FD	1. I agree with the ratio of 16 medical hours to 8 non-medical hours. After all it is a "medical Technician" certification. 2. Under Policy we should eliminate #3. Then take the phrase "and complete a verification of skills. (EMSA form SCV) Add that phrase to the ends of both #1` and #2. Thus the POLICY heading will have only two numbers. The "or" is most confusing. E.G. Obtain at least twenty-four continuing education hours (CEH) from an approved continuing education provider and complete a verification of skills. 3. Page 2, Letter B. Does this mean that every hour of every shift someone is monitored by any preceptor (possible his partner on their regular shift), will now count as CE hours? 4. Page 2, Letter J. Precepting students in the hospital is valuable and worthy of CE's for the	No change

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		preceptor. The same value should be given to the field preceptors. ICEMA should add field preceptors to this.	No change, precepting can not account for all of the education hours necessary for recertification no change.
3020	Ontario Fire	Under the definitions, just confirming that the only changes to the definitions are the order?	Yes
3030	Ontario Fire	Page 3 Under letter L – Would the instructor use the same class number as the students just on a separate roster? Would it be possible for the instructor to just turn in the roster that shows them as the instructor with the hours and the CE provider number on it – to receive CE credit? Otherwise, you will have a roster with just one name on it and who is the instructor of the instructor?	No change
3030	ICEMA	On Protocol #3030, letter "P", page 3, states EMT-II when it should read A-EMT.	Change accepted

Protocol Reference # 5040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Radio Communication 5040	AMR	Under Base Station Contact for ALS: 3. "ALS interventions" Would like to see this clearly defined as to whether the ALS unit must contact when a glucose check and monitor reading are used as an assessment tool, but the patient does not need any ALS treatment.	No change This is handled via proper education.
5040	Ontario Fire	We agree with the revision of the radio communication policy as presented in the draft. It is our opinion that these revisions will benefit the MICNs, the paramedics, and ultimately our patients by allowing each member of the "EMS chain" to focus their attention where it should be, on patient care. We anticipate that after an initial transition period the MICNs, who are arguably overwhelmed by the volume of radio reports they are currently handling, will appreciate the changes and the additional time it affords them. Additionally, the changes will allow paramedics to focus their efforts where they should be, on patient care, rather than transmitting unnecessary information simply because it's become the custom.	
5040	Rancho Cucamonga FD	Under the Purpose on the second line "The purpose of communication between EMS (add personnel) and hospitals is to relay essential information…… Adding personnel will make it consistent with the first line in the paragraph	Change accepted

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	RCFD	Page 2 – under ALS Units – Make ETA a letter D by itself to remain consistent	No change
	RCFD	Page 2 – Under Base Station communication report suggest adding a #7. To include Diversion or destination change per protocol	No change
	RCFD	Pg. 4 of 9 - #2 should read Trauma base contact.... Ground EMS personnel *and/*or aircrew (to emphasize that the aircrew should be communicating with the ground crew who is giving updates to the trauma base).	No change handle through education
5040	SACH	1) Grammatical only: pg. 4 of 9: Helicopter Transports: no need to capitalize "C" in Trauma Base contacts. Same for "prior to contact protocols" under "For Interfacility Protocol."	Accept change
		2) Page 3 of 9: under Base Stations will provide:... include "acknowledgement of prior-to-contact treatment and patient response."	Accept change
		Otherwise: well written and clear changes to a problematic protocol. VS	
5040	Barstow Fire	Good no changes needed	
5040	San Manuel FD	1. Page 1 under Purpose, consider breaking it up into paragraphs. 2. Page 1 below Purpose, We are defining three distinct reports with this protocol. We should delineate them before we describe them in	No change

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		detail. E.G. BLS REPORT given only by an EMT level BLS transporting unit. Receiving Hospital report: given by an ALS provider directly to any hospital they are in route to. When a base hospital report is not required. Base Station Report Be Given by an ALS provider to the base station 3. Page 2 Line 5, After the work medications add the phrase "not ordered by the sending physician	
5040	Ontario Fire	Under the Purpose on the second line "The purpose of communication between EMS (add personnel) and hospitals is to relay essential information…… Adding personnel will make it consistent with the first line in the paragraph	Change accepted
		Page 2 – under ALS Units – Break ETA out into letter D. by itself to remain consistent with the rest of the document	No change
		Page 2 – Under Base Station communication report Add a #7. To include Diversion or destination change per protocol	No change

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

Protocol Reference #'s 6020 and 6090

PROTOCOL #	AGENCY	COMMENT	RESPONSE
6020	Redlands Fire	Okay with deletion	
6090	Redlands Fire	Okay	
6020	Rancho Cucamonga FD	No Comments	
6090	RCFD	Fireline Paramedic- Needs some clarifying language that the fireline medic is A medic that is an individual specifically assigned to an incident as the fireline Medic. This does not pertain to the medics sent on a Type I or Type III strike Teams.	No change. This is a specialty program and the description of the medic duties is in the application.
6020 and 6090	SACH	Agree with deletions and changes. VS	
6090	Barstow Fire	Good no changes needed	
6020	San Manuel FD	I agree with its removal	
6090	San Manuel FD	I agree with ICEMA's adaptation of the fire scope guidelines.	
6020	Ontario Fire	No Comments	
6090	Ontario Fire	No Comments	

Protocol Reference #'s 10160 and 11040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
10160	Redlands Fire	Field Assessment items 7 and 8 are interpreted to say axial spinal stabilization is clinically indicated on every ALOC, anyone who has had one drink of alcohol, and if they cannot communicate in the same language as the responders. This should include some sort of trauma.	No change. This is clarified in the opening statement of the protocol.
10160	Rancho Cucamonga FD	Page 1 – Take number 7 Altered mental status and add it under number 4 to read: "Unconscious or altered mental status patients where the mechanism of injury is unknown".	No change
	RCFD	Axial spinal Stabilization- bottom of page 1 of 2. Why do we want to remove a Person from AS Stabilization? Do we know how often a patient is taken out of SI? Still not that comfortable with it. Pg. 2 of 2 #6, Should include language of any pregnant women with a notably gravid abdomen be placed in left lateral. (You can have some 2nd trimester ladies with pretty big bellies that could have the same effect).	No change No change
11040	RCFD	No Comments	
10160	SACH	1) Suggest the following wording:	
		"Any patient in which ….. not limited to the following: Those who…" Then follow with each criteria that	

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		grammatically agrees, i.e.,	
		1) Meet the mechanism of injury criteria… 2) Have soft tissue damages associated with… 3) Are unconscious or altered and the mechanism is unknown… 4) Have cervical pain or pain to the … And so on. I think it flows better with this change.	No change
		2) Suggest this wording of the last paragraph of that section : "ALS personnel may remove axial spinal stabilization placed by first responders or BLS personnel only if the patient does not meet…"	No change
		Agree with content. VS	
11040	SACH	Agree to change. VS	
10160	Barstow Fire	Good	
11040	Barstow Fire	No change needed	
10160	San Manuel FD	1. I agree with the BPM change 2. Page 2, under ALS Interventions – the last part of the sentence seems disconnected. To make it clear use: Consider Dopamine 400 mg in 250cc NS at 5-20 mcg/kg/min, titrated to sustain a systolic B/P greater than 90mmHh, (than either of the following) a. for signs of inadequate perfusion/shock. b. To relieve signs of inadequate tissue perfusion /shock.	Good comment, refer to Protocol Education Committee (PEC) for review and change.
10160	Ontario Fire	Page 1 – Take number 7 Altered mental status and add it under number 4 to read: "Unconscious or altered mental status patients where the mechanism	No change

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		of injury is unknown"	
		Under the last paragraph ALS personnel may remove patients placed in axial spinal stabilization by First Responders and/or BLS personnel if the patient does not meet any of the above.....	No change
11040	Ontario Fire	No Comments	

QI PLAN

PROTOCOL #	AGENCY	COMMENT	RESPONSE
QI Plan	Redlands Fire	On page four the link between the Regional QI groups and the Central QI is missing.	
QI Plan	Redlands Fire	On page five, item number eight, the term "State of Art" is ambiguous.	
QI Plan	Redlands Fire	On page 21, item C-1 is requesting that we review 30 or 10% of the monthly runs. Randomly choosing 30 or more runs is not an effective way to manage a QI program. It would be a better practice if providers can QI a specific call type and report their findings. The way the plan is written now, ICEMA wants to see the providers QI at least 30 runs, which include all MCIs, AMAs, ET tube insertions, and other factors. This is fine except for the fact that many departments will fall into the 10% category, which could easily amount to 50 to 70 runs per month. The problem is not the amount of calls to QI but what objective parameters are established to form an improvement program. Having a provider define the objective parameters and notify ICEMA before a review occurs will create a more robust QI program.	No change. Random audits of runs are an effective way of identifying indicators that will require closer scrutiny. QI plan has been extensively reviewed and discussed at appropriate committees with appropriate constituency input in its development.
QI Plan	Redlands Fire	On page 21, item C-3 discusses QI form 005 but there is no form to view. Is this the form that is used to submit the monthly QI reports? Is there a format for the monthly report? If the provider report is submitted annually, what will the regional and Central QI groups discuss when they have their monthly and quarterly meetings?	Forms will be available once plan approved. Education will be provided
QI Plan	Rancho Cucamonga FD	A BIG thank you for completing this document. It is an excellent document and great starting point for all of the agencies that are rewriting their CQI Plan. Pg. 5 # 1 might read better by switching provide constantly to constantly provide (A small item for easier reading)	No change
	RCFD	Pg 8 Should there be a spot for the ICEMA QI	

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		representative (nurse or EMT-P) From ICEMA?	
	RCFD	Pg 15- B 1. Clarify # of runs to review. 30% should include random audits and requested reviews. PLNs do a large number of requested reviews and adding 30% random on top of the already large work load may be too much. We agree with the 30%, but it should include many of the audits already being done as part of the role of PLN.	No change See previous comment in this topic
	RCFD	Pg. 21 C. 1 Lots of PCRs are reviewed, but not always randomly. The number of audits should include the reviews already being conducted along with a % of random audits such as 5-7 % (same as above). Specific reviews are equally as important as random reviews and should be recognized in the total amount.	No change
	RCFD	Page 22 under Review of Patient Care Data ALS Run Report Forms – Add H. Advanced Scope Skills	No change This is a specific indicator. Specific indicator will be decided by the Central QI Committee.
	RCFD	Page 24 under Conducting a Case Review Conference 2. Review of Information b. No Further Action Necessary – Remove the word investigation and replace with review (discussed in QI committee meeting to remove all language using Investigations) c. Need for Education – can you add Agency Medical Director so that both the Base Hospital Medical Director and the Agency Medical Director	Change accepted

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		are able to determine the need for education	
	RCFD	**Thank you for the opportunity to make comments. Great work done by all involved.**	
QI Plan	SACH	1) Page 14: III.A.- What is meant by "specialty care hospitals"? And why are they included in the Base Station CQIP?	Good comment. We will change to "Critical Care Specialty Hospitals" STEMI, Trauma, Stroke
		2) Definition of CQIP Technical Advisory Group?	
		3) Page 15: B. 1. REVIEW OF PATIENT CARE DATA: The requirement of 10% randomly selected MICN reports with waveforms is a waste of valuable CQI time. Our facility finds that CQI focused on newer protocols (such as STEMI or Stroke) or protocols with infrequent use (ROSC or Trauma), and runs referred by the MICN staff, and/or other EMS providers is more productive. Auditing a clinical topic selected by the CCQIC or RCQIC would also be more valuable than random audits.	No change. The specialty programs and specialty destination policies have their own QI groups as subdivisions of the overall QI program. The CQI program looks at everything in the system. Random audits identify issues with the system that may not be obvious when focusing on specific protocols
QI Plan	Barstow Fire	Complicated but very good no change.	
QI Plan	San Manuel FD	1. Page 4 under ORGANIZATION CHART we should add two boxes. One for the PEDS death QI and one in anticipation of the Stroke QI. Both will need to be defined in this document. 2. Page 4 under CQI mission. At the end of the mission add "There by advancing the discussion of evidenced based care and mike it our mission. 3. Page 5 add a #10 "The CQI process will generate changes in our EMS system and will	The Child Death Review Committee is a County wide committee consisting of social workers, district attorneys, and others. It is not an ICEMA committee. Stroke QI can be added to the committees as needed. Committee designation and org chart may be updated without affecting the CQI plan.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		result in the modification of the CQI process itself."	
		4. Page 7 Committees. There is no mention of whether a meeting is closed or open. Except for the Trauma and Air Audit Committee which is designated as a closed meeting. Please add this distinction to all the other committee meetings.	No change We indicate meetings that are closed on the website.
		5. Page 8 under Central Continuous Quality Improvement committee. I would like to see two additions; a. Native American EMS representative b. Air ambulance representative. There is a possibility we may need an air ambulance CQI committee that will report to the central CQI. If adopted the air ambulance committee should be defined in this document and added to page 7's flow chart.	No change
		6. Page 16 Wave reviews please use another name for this. I believe it is a recorded audio file.	Change accepted " Audio file"
		7. Page 14 with regard to base station requirements; the base stations cannot be expected to accomplish the amount of work outlined in the policy. It requires; MICN reports, wave reviews, concurrent and retrospective clinical reviews, statistical data gathering m case review reports annual CQIP reports, quarterly reports. IN most cases this is assigned to only one person. We have precious few base hospitals presently. I hope we do not lose another one due to excessive workloads and expenses. The amount of work this policy will require of them is not reasonable. The cost in	No change. Actual reviews and studies will be determined by the Central QI Committee and will take into account work loads and feasibility of the reviews. Most of the data we will be looking at is gathered by the base stations already.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		overtime and personnel is far more than can be absorbed with the present economic situation. Our base hospitals have more than enough responsibility regulating STMEI, Trauma, Stroke as well as EMS and walk in traffic, The base hospitals should review as they presently do. Reports should be given to the EMS directors of each agency as needed. Trends should be reported to ICEMA as it is presently done. While this policy is ideal it is far too aggressive for the current economic climate. The question could be asked that, at what point does the regulating agency become responsible for the cost of the policies it requires of others.	
QI Plan	Ontario Fire	Page 22 under Review of Patient Care Data A. ALS Run Report Forms – Add H. Advanced Scope Skills	No change This is a specific indicator. Specific indicator will be decided by the Central QI Committee.
		Page 24 under Conducting a Case Review Conference 2. Review of Information b. No Further Action Necessary – Remove the word investigation and replace with review (discussed in QI committee meeting to remove all language using Investigations) c. Need for Education – can you add Agency Medical Director so that both the Base Hospital Medical Director and the Agency Medical Director are able to determine the need for education	Change accepted Change accepted

45 Day Comment Period for Protocols
October 26, 2010 thru December 10, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	Ontario Fire	Thank you for the opportunity to make comments. Excellent work on all documents done by ICEMA and committees.	

MICN CERTIFICATION REQUIREMENTS

PURPOSE

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

PROCEDURE

Initial MICN Certification

1. Possess a current California RN License

2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:

    a. Fee as set by ICEMA. The fee is not refundable or transferable.

    b. Written verification of employment at a designated Base Station within the ICEMA Region.

    c. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.

    d. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.

    e. Copy of current government issued photo identification (i.e. Driver's License)

3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.

4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.

5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.

a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a score of at least 85%.

b. A candidate who fails to pass the ICEMA written examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA written examination with a minimum score of 85%.

c. If the candidate fails to pass the ICEMA written examination on the third attempt, the applicant must repeat the course and reapply.

6. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.

8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

9. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Continuous MICN Certification

1. Possess a current California RN License and current ICEMA MICN certification.

2. Submit the appropriate completed ICEMA application with:

a. Written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other

CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA)

b. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.

c. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.

d. Documentation of eight (8) hours of field time.

e. Documentation of one (1) ICEMA approved Skills Day.

f. Documentation of six (6) hours of field care audits obtained within the ICEMA region.

g. Documentation of two (2) consecutive ICEMA Annual Review Class (ARC), one during each year of certification.

h. Continuous certification applicants not meeting the above requirements must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a minimum score of 80%.

ICEMA written examination does not replace or fulfill the requirement for a Skills Day or Field Care Audits. These must be completed prior to recertification.

3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.

4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.

5. Individuals certified less than six (6) months must submit a new application and a current state license. No education is required and a fee is not applicable.

   Individuals certified more than six (6) months but less than one (1) year must submit a new application, items a-c above and complete one (1) ARC, three (3) hours of field care audits and either a skills day or eight (8) hours of field time.

   Individuals certified more than one (1) year must complete all requirements.

Inactive MICN Certification

1. Maintain a current California RN License.

2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.

   a. Copy of front and back of a current, signed ACLS Card.

   b. Copy of front and back of current California RN License.

   c. Documentation of one (1) ICEMA approved Skills Day taken during the year of inactivation.

   d. Documentation of six (6) hours of field care audits obtained within the ICEMA region.

   e. Documentation of one (1) ICEMA Annual Review class for each year of inactivation.

Return to Active MICN Status

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Station within the ICEMA Region.

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

2. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.

3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.

4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.

5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

6. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Certification by Challenge Examination

1. Possess a current California RN License.

2. Meet one (1) of the following eligibility requirements:

   a. MICN in another county within previous twelve (12) months

   b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status

3. Submit the appropriate ICEMA application with:

   a. Fee as set by ICEMA.

   b. Written verification of employment at a designated Base Station within the ICEMA Region.

   c. Copy of front and back of a current, signed ACLS Card.

   d. Copy of front and back of current California RN License.

4. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.

5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA written examination.

6. Upon passing the ICEMA written examination with a minimum score of 80%, a provisional MICN card will be issued.

   a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the written examination with a minimum score of 85%.

   b. A candidate who fails to pass the ICEMA written examination on the second attempt will be deemed ineligible for challenge certification. Applicant will

need to take an ICEMA approved MICN course and comply with initial certification requirements.

7. The individual may then function as a provisional MICN under the direct supervision of the Base Station MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.

8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).

9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

10. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

MICN Recertification for RN's Working in a Non-Base Station (MICN – A)

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

a. Must complete 2c through 2e under Initial Certification above.

b. Fee as set by ICEMA

c. Must submit proof of employment with an approved non base station employer.

d. Must teach or attend an additional skills day.

e. Must teach or attend an additional six (6) hours of field care audits.

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

This certification may be converted to regular MICN status upon written verification of employment at a designated Base Station within the ICEMA Region.

FLIGHT NURSE AUTHORIZATION

PURPOSE

To define the requirements for EMS Aircraft Flight Nurse Authorization within the ICEMA Region.

PROCEDURE

Initial Authorization

1. Fee as set by ICEMA. The fee is not refundable or transferable.

2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

   If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received by ICEMA within thirty (30) days.

3. Copy of current government issued photo identification (i.e. Drivers License).

4. Copy of front and back of a current, signed ACLS Card.

5. Copy of front and back of current California RN License.

6. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.

7. Proof of attendance of four (4) hour Flight Nurse Orientation course.

8. Upon passing the local authorization written examination with a minimum score of eighty percent (80%), a Flight Nurse Authorization card will be issued with the same expiration date as the candidate's RN license.

9. Flight Nurse Authorizations issued within six (6) months of nursing license expiration are exempt from reauthorization fee.

REAUTHORIZATION

Submit the Flight Nurse Reauthorization application form with the following:

1. Fee as set by ICEMA. The fee is not refundable or transferable.

2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

   If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received within thirty (30) days.

3. Copy of front and back of a current, signed ACLS Card.

4. Copy of front and back of current California RN License.

5. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.

CONTINUING EDUCATION PROVIDER REQUIREMENTS

PURPOSE

To define the requirements for approval of Continuing Education (CE) Providers within the ICEMA Region.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

DEFINITIONS

Emergency Medical Services (EMS) Continuing Education (CE) Provider: An individual or organization approved by the requirements of Title 22, Division 9, Chapter 11, to conduct continuing education courses, classes activities or experiences and to issue earned continuing education hours to EMS personnel for the purpose of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Continuing Education: A course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

Clinical Director: A person currently licensed as a physician, registered nurse, physician assistant or paramedic. The clinical director shall have had two (2) years of academic, administrative or clinical experience in Emergency Medicine or EMS care within the last five (5) years. The clinical director shall be responsible for monitoring all clinical and field activities approved for CE credit, approving instructors and monitoring the overall quality of the EMS content of the program.

Program Director: A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations and ICEMA policy.

Instructor: A person approved by the program director and clinical director as qualified to teach the topics assigned or have evidence of specialized training which may include, but is

not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

PROCEDURE

1. To become an approved CE provider, an organization or individual shall submit an application packet at least sixty (60) days prior to the date of the first educational activity. The application packet shall include:

    a. Name and address of the applicant;

    b. Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;

    c. Type of organization requesting approval;

    d. Program director and clinical director resumes including copies of all licenses/certifications; and,

    e. ICEMA approved fee.

2. The applicant will be notified in writing within fourteen (14) working days that their request was received and informed if any information is missing.

3. Notice of approval or disapproval of the application will be made in writing to the applicant within sixty (60) calendar days of receipt of the completed application.

4. If the application is approved, an EMS CE provider number will be issued and valid for four (4) years.

5. If an application is disapproved and the organization or individual elects to submit a new application, the application packet must include all items listed in "1" above.

MAINTAINING RECORDS

1. All records will be maintained by the CE provider for four (4) years, and shall include:

    a. Complete outlines for each course given including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.

b. Record of time, place, date and CE hours granted for each course.

c. A resume and copies of licenses/certifications for all instructors.

2. An ICEMA approved CE roster:

a. Signed by course participants to include name and license/certification/accreditation number of each participant. Signing for another individual is strictly prohibited and subject to actions against certification or licensure.

b. A line should be drawn through any empty lines after the last attendee has signed the roster.

c. Copies of class rosters shall be sent to ICEMA within fifteen (15) days of class completion. These rosters shall be considered final and revisions will not be accepted.

d. A record of all CE certificates issued.

3. CE providers will notify ICEMA within thirty (30) calendar days of any changes in name, address, and telephone number of the program director, clinical director or contact person.

4. All records shall be made available to ICEMA upon request.

5. The Clinical Director shall submit a complete list of courses with the number of individuals attending each course on a monthly basis to ICEMA on the ICEMA approved form. The form shall be submitted to ICEMA by the 10th of every month for the previous month. If no classes were taught, submit form with "No Classes This Month"

6. It is the responsibility of the CE provider to submit an application for renewal with the ICEMA approved fee at least sixty (60) calendar days prior to the expiration date in order to maintain continuous approval.

7. All CE provider requirements required by State legislation must be met and maintained.

POLICY

1. When two (2) or more CE providers cosponsor a course, only one (1) approved provider number may be used for that course, class or activity. The CE provider

assumes the responsibility for all applicable provisions of Chapter 11 EMS Continuing Education.

2. The State EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved by the Continuing Education Board for Emergency Medical Services (CECBEMS) or approved by the EMS offices of other states or courses in physical, social or behavioral sciences offered by accredited colleges and universities.

3. An approved CE provider may sponsor an organization or individual located within California that wishes to provide a single activity or course. The CE provider shall be responsible for ensuring the course meets all requirements and shall serve as the CE provider of record. The CE provider shall review the request to ensure that the course/activity complies with the minimum requirements.

EMT CONTINUING EDUCATION REQUIREMENTS

PURPOSE

To define requirements for continuing education for certified Emergency Medical Technicians (EMT's) in the Counties of San Bernardino, Inyo and Mono.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

POLICY

To maintain certification, an EMT shall:

1. Obtain at least twenty-four hours' (24) continuing education hours (CEH) from an approved continuing education provider ***or***

2. Complete a twenty-four (24) hour refresher course meeting National Standard Curriculum from an approved EMT training program.

3. Complete a verification of skills. (EMSA Form SCV)

DEFINITIONS

1. Continuing education (CE) is a course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as the knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

2. A continuing education hour (CEH) consists of a minimum of fifty (50) minutes of approved classroom or skills laboratory activity. CE courses or activities shall not be approved for less than one (1) hour of credit. For courses greater than one CEH, credit may be granted in no less than half hour increments.

CONTINUING EDUCATION

1. Continuing education hours may be earned in the following manner:

   a. Any of the topics contained in the respective National Standard Curricula for training EMS personnel.

   b. Each hour of structural clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to this division.

   c. Each hour of media based/serial production CE (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules) A maximum of twelve (12) CE hours may be obtained in a twenty-four (24) hour period.

   d. Classroom, didactic and/or skills laboratory with direct instructor interaction

   e. Organized field care audits of patient care records

   f. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care

   g. Courses offered by accredited universities and colleges, including junior and community colleges. Acceptable courses include physical, social or behavioral sciences (i.e. anatomy, physiology, sociology, psychology) Credit shall be given on the following basis:

      1) One academic quarter unit shall equal ten (10) CE hours

      2) One academic semester unit shall equal fifteen (15) CE hours

   h. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;

   i. Sixteen (16) hours of required CEHs must come from courses involving medical management of patients. Non-medical EMS system courses (e.g. ICS, HazMat FRO, Vehicle Extrication, Rope Rescue, etc) will be limited to eight (8) hours maximum per certification cycle.

   j. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base hospital. In order to receive CEHs for precepting, all the requirements

for a course including objectives and student evaluations of the preceptors. CEHs for precepting are limited to a maximum of fifty percent (50%) of required continuing education hours per licensure/certification cycle for all EMS personnel.

k. At least fifty percent (50%) of the required CE hours must be in an instructor-based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on-line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.

l. An instructor for a CE course, class or activity will earn credit equal to the same number of CEHs applied to the course, class or activity. This shall be documented on a separate roster, clearly labeled "Instructor" and include the course name. Credit will be given, one time only, for each specific course, during a certification/licensure cycle.

m. Credit may be given for taking the same CE course, class or activity no more than two (2) times during a single certification cycle.

n. At the time of the educational event, the student must sign and provide certification/licensure number on the Continuing Education Course Roster. Failure to do so will result in loss of CE credit.

o. An individual shall provide proof of approved continuing education hours obtained to ICEMA upon request and at the time of application.

p. An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within six (6) months of the date of application may be given credit for continuing education hours earned as a Paramedic or EMT-II to satisfy the continuing education requirement for EMT recertification.

q. Continuing education may be obtained at any time throughout the current certification period.

RADIO COMMUNICATION POLICY

PURPOSE

To define the requirements for communication reports between EMS personnel and hospitals. The purpose of communication between EMS and hospitals is to relay essential information to allow the hospital to prepare for the patient, and as necessary, to allow a Base Station to provide Medical Control and consultation to the ALS provider. The communication report should be brief, concise, and include only the information that impacts the care of the patient in the field, and when the patient initially arrives in the hospital. It should not include unnecessary information, or impede the EMS providers focus on patient care. The communications report is not intended to be the complete patient report nor is it equivalent to the "face-to-face" report to the Emergency Department staff at the hospital. Communication reports should be given to the hospital by EMS while on scene, or as soon as possible after departing the scene. Transport of unstable patients, or patients meeting Trauma Triage Criteria shall not be delayed for a communications report. ALS providers may only accept orders from Base Stations within the ICEMA region. Patient names shall not be given over the radio except at the request of the base station physician, and with the prior approval of the patient. Base Station Physicians may give any medically appropriate order within the prehospital provider's scope of practice.

BLS UNITS

BLS communication reports contain minimal information since BLS units:

a) Cannot be diverted; and

b) Cannot carry out medical control orders

BLS communications reports contain:

a) The EMS unit identifier, and that it is a BLS report;

b) The patient's age, sex, chief complaint/injury, and ETA;

c) Vital signs, Glasgow Coma Scale, and other pertinent signs/symptoms and information.

ALS UNITS

Receiving Hospital communication reports are designed for:

Informing the ***receiving*** hospital (Base station or otherwise) of incoming patients not requiring medical control orders or consultation.

Receiving Hospital communications reports contain:

a) The EMS unit identifier, that it is a ***receiving hospital*** report, and the provider's name/certification level;

b) The patient's age, sex, chief complaint/injury and ETA;

c) Information that impacts patient care.

Base Station communication reports are for:

1. Requesting consultation or medical control orders from a Base Station;

2. Informing or consulting with a Specialty Base Station (Trauma, STEMI, Stroke Center, etc…)

3. Patients receiving ALS interventions:

    a. Who do not improve; or

    b. Who are not being transported by ambulance; or

    c. Prior to terminating resuscitative efforts.

4. All patients under nine years old that are not transported by ambulance. Base Station contact shall be made while the EMS provider is on scene (if safe).

5. Interfacility transfers needing medications and/or a destination change per protocol #8010.

6. Multiple Casualty Incidents (MCI) per protocol #5050.

Base Station communications reports are to contain:

a) The EMS unit identifier, that it is a ***Base Station*** report, and the provider's name/certification level;

b) The severity of the patient, and if the patient is a "specialty" patient (Trauma, STEMI, Stroke, etc.);

c) Patient age, sex, general appearance, weight in kilos, and level of responsiveness (or Glasgow Coma Scale when appropriate);

d) Chief complaint/injuries, and mechanism of injury/patient situation;

e) Vital signs, cardiac monitor reading, and remarkable physical exam findings;

f) Pertinent medical history;

g) Prior to contact treatment initiated and patient response;

h) Information that impacts patient care;

i) ETA.

Base Stations will provide:

a) Contact time, and the name of the MICN (and Base Station Physician when present);

b) Consultation and medical control orders appropriate to the patient condition.

PATIENT DESTINATION

Patient/guardian/family/law enforcement requests for a given hospital with Emergency Department capability should be honored. Exceptions may include:

a) Patient condition and/or protocol require transport to a closer or more appropriate (Specialty) hospital.

b) All patients on a 5150 hold must go to the closest facility for medical clearance prior to transfer to a psychiatric facility.

c) Requested hospital is on internal disaster.

d) Requested hospital is significantly beyond the primary transport area of the transporting department or division.

In cases where the patient/guardian is demanding transport to a facility against the judgment of the paramedic, Base Station contact will be made, and patient destination becomes the responsibility of the Base Station Physician. If the patient/guardian continues

to demand transport to a facility against the judgment of the Base Station Physician, they must be informed of the risks of their decision, up to and including death. The patient/guardian may sign a Release of Liability to go to their hospital choice. The Patient Care Report will document the circumstances of the refusal.

HELICOPTER TRANSPORTS

In San Bernardino County, the San Bernardino County Communications Center (Comm Center) will assign the destination hospital for trauma patients when a request for a helicopter is received.

1. When possible, Comm Center will notify both the ground EMS units and the responding helicopter of the assigned destination hospital.

2. Trauma Base Contact should be made as soon as practical by the ground EMS personnel or the aircrew.

3. Whenever possible, **Trauma Base Contact will be made with the Trauma Hospital that will actually be receiving the patient.**

4. Upon arrival of the helicopter, the ground EMS personnel will give a patient report to the aircrew, and include:

   a) The assigned destination hospital (if known);

   b) If Trauma Base Contact has been made (and with which Trauma Base); and

   c) If the assigned destination hospital was changed (and the reason for the change).

5. The helicopter aircrew will contact the *actual* receiving Trauma Hospital to:

   a) Request a landing pad assignment;

   b) Provide a patient report, or update on patient condition; and

   c) Inform them if Trauma Base Contact was originally made with a different Trauma Base.

If the original Trauma Base Contact was made with a different Trauma Base, the actual receiving Trauma Hospital will notify the original Trauma Base of the change in destination.

INTERFACILITY TRANSPORT GUIDELINES (ALS) PROTOCOL 8010

Interfacility transport patients with a deteriorating condition significant enough to require medication administration and/or a destination change require Base Station contact.

a. Paramedics may initiate Prior to Contact protocols, and shall make Base Station contact. The Base Station will be notified of the status change of the patient, the medications administered prior to contact and any need for further orders or destination changes.

b. The Base Station shall notify both the sending facility and the original receiving facility of a destination change.

c. The Base Station will include an evaluation of any destination change in their ICEMA CQI report.

EMT AED SERVICE PROVIDER POLICY

DELETE POLICY

PURPOSE

To establish a standard mechanism for approval and designation of EMT AED Service Providers in the ICEMA region.

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9., Chapter 2 Emergency Medical Technician I.

POLICY

ICEMA shall approve all EMT AED service providers prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

EMTAED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit the following to ICEMA for review and approval prior to beginning service:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications and the training program to be used.
5. Policies and procedures to ensure orientation of AED authorized personnel.
6. Procedures for maintenance of the AED.
7. Policies and procedures to collect, maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.

DELETE POLICY

RECORD KEEPING AND REPORTING REQUIREMENTS

1. The following data will be collected and reported to ICEMA by March 1 for the previous calendar year.

   a. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.

   b. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed.

   c. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.

2. Provider must maintain a listing of all AED personnel and provide upon request to ICEMA.

DELETE POLICY

FIRELINE PARAMEDIC

PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic deployed to function as a fireline paramedic.

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

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220 California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167 California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, (3-2002). California Code of Regulations Title 22, Division 9, Section 100165 (l) states: *"During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting local EMS agency."*

DEFINITIONS

Fireline Emergency Medical Technician-P (FEMP): A paramedic who meets all prerequisites established by FIRESCOPE and is authorized by the paramedic's department to provide ALS treatment on the fireline to ill or injured fire suppression personnel.

REQUIREMENTS

1. Must be a currently licensed paramedic in California.
2. Must be currently accredited paramedic in the ICEMA region.
3. Must be currently employed by an ICEMA approved ALS provider.
4. The FEMP will follow FIRESCOPE FEMP ICS 223-11 Position Manual and all other ICS protocols.
5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.
6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.

7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.

8. The FEMP may not perform skills outside of the ICEMA scope of practice.

PROCEDURE

1. The provider agency will notify ICEMA of the deployment of the FEMP to an incident.

2. The FEMP will carry inventory in the ALS pack as per the attached inventory list. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.

3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.

4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.

5. FEMP may carry an inventory of controlled substances (i.e. Morphine and Midazolam) if authorized by the employing agency's Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.

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

7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care reports will be reviewed by the provider agency and ICEMA for QI purposes.

8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with BLS treatment and supplies.

FIRELINE EMT-P (ALS) PACK INVENTORY

Minimum Requirements. *The weight of the pack will dictate if the paramedic chooses to carry additional ALS supplies.*

ALS AIRWAY EQUIPMENT

1. Endotracheal intubation equipment:
    a. 6.0, 7.0 and/or 7.5 ET
    b. Mac 4, Miller 4, and handle (pediatric suggested for weight)
    c. Stylet and/or gum elastic intubation stylet
2. King Airway -- one each - Size 3, 4 and 5
3. ET tube holder
4. End tidal CO2 Detector
5. Needle cricothyrotomy kit
6. Needle thoracostomy kit

IV/MEDICATION ADMINISTRATION SUPPLIES

1. IV administration set macro drip (2)
2. Venaguard (2)
3. Alcohol preps (6)
4. Betadine swabs (4)
5. Tourniquet (2)
6. Razor (1)
7. Tape (1)
8. IV catheters 2 each - 14, 16, 18 and 20 gauge
9. 10cc syringe (2)
10. 1 cc TB syringe (2)
11. 18 gauge needle (4)
12. 25 gauge needle (2)
13. Lancets

MISCELLANEOUS

1. Sharps container (1)
2. Narcotic storage per protocol
3. FEMP pack inventory sheet (1)
4. Patient care record or ePCR (Toughbook)
5. AMA forms (3)

EQUIPMENT

1. Compact AED or compact monitor defibrillator combination
2. Appropriate cardiac pads
3. Pulse oximetry (optional)
4. Glucometer and test strips (4)

MEDICATIONS

1. Albuterol Solution 2.5 mg (4) Handheld Nebulizer or Multidose Inhaler
2. Atropine Sulfate 1 mg (2)
3. Ipratropium Bromide Solution 0.5mg (4) Handheld Nebulizer or Multidose Inhaler
4. Lidocaine 100 mg IV pre-load (2)
5. Aspirin 80 mg chewable bottle (1)
6. Dextrose 50% 25gm pre-load (1)
7. Diphenhydramine 50 mg (4)
8. Epinephrine 1: 10,000 1mg (2)
9. Epinephrine 1: 1000 1mg (4)
10. Glucagon 1mg (1)
11. Midazolam 20 mg
12. Morphine Sulfate 10 mg/ml (amount determined by the medical director)
13. Nitroglycerin spray 0.4 metered dose (1)
14. Saline 0.9% IV 1000 ml may be divided in two 500ml bags or four 250 ml bags.

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

AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to the following:

1. Patient meets Mechanism of injury as described in Protocol reference #15030, Trauma Triage Criteria and Destination Policy

2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles

3. Unconscious patients where the mechanism of injury is unknown.

4. All intubated neonatal and pediatric patients.

5. Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.

6. Altered mental status.

7. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).

8. Additional sites of significant distracting pain or is experiencing emotional distress.

9. Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.

10. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.

11. Any other condition that may reduce the patient's perception of pain.

ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel if the patient does not meet **any** of the above indicators after a complete assessment and documentation on the patient care record:

INTERVENTIONS

1. Apply manual axial stabilization.

2. Assess and document distal function before and after application.

3. For pediatric patients: If the level of the patient's head is greater than that of the torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.

5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.

6. When a pregnant patient in the third trimester is placed in axial spinal stabilization, place in the left lateral position to decrease pressure on the Inferior Vena Cava.

7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

BRADYCARDIAS - ADULT

ASYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Heart rate less than 60 bpm.

2. Signs of adequate tissue perfusion.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm..

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

3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider bolus of 300cc NS, may repeat.

2. Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital

SYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs of inadequate tissue perfusion/shock.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.

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

3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Consider advanced airway, as indicated.

2. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation.

3. Place on Cardiac monitor and obtain rhythm strip for documentation. Provide copy to receiving hospital.

4. Administer Atropine 0.5mg IVP. May repeat every five (5) minutes up to a maximum of 3mg or 0.04mg/kg.

5. **Consider TCP**, per Protocol Reference #10110, instead of Atropine for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block.

6. Attempt transcutaneous cardiac pacing of a bradycardic rhythm with continued symptoms of inadequate tissue perfusion.

7. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P greater than 90mmHg, and signs of inadequate tissue perfusion/shock.

8. Contact Base Station.