



MONO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE



Mammoth Hospital
ED Lounge/Conference Room

May 25, 2010
9:00 a.m.

A G E N D A

- I. CALL TO ORDER**
- II. APPROVAL OF MARCH 23, 2010 MINUTES**
- III. ICEMA UPDATE**
 - A. Personnel Update
- IV. EMS SYSTEM MANAGEMENT REPORTS**
 - A. Scantron Data
 - B. Base Hospital Report
- V. NEW BUSINESS**
 - A. Symons Ambulance
 - B. EMTs and First Responders
 - C. Implementation of 2010 EMT Regulations
 - D. ICEMA Fee Schedule 2010/2011
 - E. Nasal Administration of Medications
 - F. Protocols
 - 1. Reference #1050 MICN Certification Requirements
 - 2. Reference #1080 Flight Nurse Authorization
 - 3. Reference #6050 Pulse Oximetry Service Provider Requirements
 - 4. Reference #6080 Paramedic Blood Draw for Chemical Test at the Request of a Peace Officer
 - 5. Reference #8010 Interfacility Transfer Guidelines
 - 6. Reference #9020 Physician on Scene
 - 7. Reference #9040 Reporting Incidents of Suspected Abuse
 - 8. Reference #9050 Organ Donor Information
- VI. OTHER/PUBLIC COMMENT**
- VII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**
- VIII. NEXT MEETING DATE AND LOCATION**
- IX. ADJOURNMENT**

The Mono 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



MONO COUNTY EMCC MEETING

Mammoth Hospital
A/B Conference Room
Mammoth Lakes, CA

MINUTES
March 23, 2010

Committee Members	Affiliation
<input checked="" type="checkbox"/> Mark Mikulicich	Mono County Paramedic Rescue Chief
<input checked="" type="checkbox"/> Dr. Rick Johnson, MD	Mono County Health Officer
<input checked="" type="checkbox"/> Bob Rooks	Mono County Fire Chief's Association
<input checked="" type="checkbox"/> Lori Baitx, RN	Mammoth Hospital
<input checked="" type="checkbox"/> Rosemary Sachs, RN	Mammoth Hospital

Other Attendees	Affiliation
Diane Fisher	ICEMA
Ray McGrale	Mono County Paramedic Rescue
Edward Soto	Project Officer, Region IV
Temple Fletcher	Care Flight Representative

I. CALL TO ORDER

The meeting was called to order at 9:10 a.m.

II. APPROVAL OF JANUARY 26, 2010 MINUTES

Prior to a motion to approve the minutes, there was further discussion concerning some of the issues that Lori Baitx had with Sierra LifeFlight. She updated the group regarding conversation with Mike Patterson. The issue will be resolved with better communication in the future. Rosemary Sachs noted that she has been aware of potential problems with American Med Flight and has asked for input from the medics which has yet to materialize. Lori Baitx mentioned that the hospital has been courted by several other flight services, and that American Med Flight could be "bumped" down the availability list if they fail to provide good service. Temple brought the committee more information and a list of California Flight Service providers, which was set aside until later in the meeting. After no further discussion, Rosemary Sachs motioned to approve the minutes and seconded by Bob Rooks. Minutes were approved with all voting members in favor.

III. NEW BUSINESS

A. Personnel Update

1. Virginia Hastings, ICEMA Executive Director, has a new secretary, Jacquie Martin.
2. There is a new ICEMA trauma nurse – Christine McMath.

B. Ambulance Rates

The San Bernardino County Board of Supervisors has approved a new policy from ICEMA dealing with ambulance rates. The rates are based on CPI and increases based on fuel costs and additionally compared to “like” counties. Maximum increases of 5% per year until comparable. Rural areas are having higher rates due to increased operating costs per patient numbers.

Dr. Johnson commented that Judd Symons (Symons Ambulance) has reduced available personnel and ambulances due to the decreases in Medicare (28%?). It was suggested that Mark Mikulicich talk with Judd to determine how this may affect mutual aid for southern and eastern Mono County communities.

Ray McGrale said he had heard that Judd was planning on staffing his 2nd out rig on an “on call” basis.

Bob Rooks mentioned (in regards to rates) that Mono County has always set rates based on “like counties”, and Mark Mikulicich confirmed this with his explanation of the rate study performed prior to the last substantial rate increase several years ago.

Diane confirmed that the policy allowed for a 10% increase in rate parameters for rural providers due to low volume.

Lori Baitx had to depart at 09:30.

C. San Bernardino County Air RFP

San Bernardino County is going out to RFP for air ambulance providers (rotary). This is all still in process; it will go to the Board and then the State for approval prior to publication. The time to completion is likely to be 6- 9+ months. Other counties (such as Kern) are doing the same.

D. King Airway Survey

Ray McGrale logged on and completed the survey. Mono and Inyo counties are utilizing the King Airway.

E. EMS MISS Status Report

ICEMA is also in the process of preparing a RFP for new software. Bob Rooks asked if there will be software fees, and Diane Fisher indicated that it is anticipated that ICEMA will be able to purchase software licenses for San Bernardino County providers using liquidated damage funds. Discussion needs to follow regarding Inyo and Mono County users.

09:38 Ed Soto came into the meeting and introductions were made all around.

IV. EMS SYSTEM MANAGEMENT REPORTS

A. ALS/BLS Reports

Updated scantron information presented.

B. Base Hospital Report

Information presented on nice graph.

C. ePCR Update

Mono County still on paper!

V. NEW BUSINESS

EMT National Registry Exam Results

Results show that Ray McGrale has a high percentage of passing students (good job Ray!). Ray said the toughest part about teaching EMT (to this rural, volunteer demographic) is getting people to be good test-takers. Many of the individuals that are willing to volunteer for their local Fire Departments struggle to complete EMT due to a lack of academic skills. This is not a new problem in the vary rural areas, and one possible solution is to change BLS ambulance staffing requirements from two EMTs on board, to one EMT attendant and one First Responder driver. There is a general agreement by the Committee that supports this line of thought -- it's better to be able to provide BLS ambulance transport with an EMT and a First Responder, rather than have no ambulance at all!! The Feds and the State absolutely need to acknowledge this reality within the rural areas of our country; it makes no sense to throw the baby out with the bath water clinging to "good intentions" that just don't work!

Initially there was the idea to give credit towards EMT curriculum for students that have passed the First Responder course; ICEMA and Dr. V were warming up to the concept. Even though this concept was initially brought forth by Ray McGrale, he now feels that the idea may not be good in the sense that all hours of EMT curriculum were needed towards passing the National Registry final, and getting the DOT to change their regulations regarding EMT education and First Responder credit was next to impossible. This will be discussed further.

Bob Rooks had to leave the meeting at 10:20.

VI. OTHER/PUBLIC COMMENT

Temple brought information on the entities participating in the Cal State Task Force for air providers and a list of the air ambulances in California. (CAL-AAMS is the membership organization of the air ambulance providers in California; www.calaams.org). The agency that certifies Critical Care Transport providers is called CAMTS. They set the medical, operational and safety standards. (www.camts.org)

Temple presented the EMCC with a copy of the complete EMS Aircraft Guidelines (which is out for public comment).

VII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

Further discussion on EMTs and First Responders for next meeting.

VIII. NEXT MEETING DATE AND LOCATION

Tuesday, May 25, 2010 at Mammoth Hospital ED break room.

IX. ADJOURNMENT

11:00 a.m.

DRAFT

**REPORT/RECOMMENDATION TO THE BOARD OF DIRECTORS
OF INLAND COUNTIES EMERGENCY MEDICAL AGENCY
AND RECORD OF ACTION**



May 25, 2010

**FROM: VIRGINIA HASTINGS, Executive Director
Inland Counties Emergency Medical Agency**

SUBJECT: APPROVE 2010-11 FEE SCHEDULE

RECOMMENDATION(S)

Acting as the Governing Board of the Inland Counties Emergency Medical Agency, approve Policy # 5090 to establish 2010-11 ICEMA fee schedule, effective July 1, 2010.

(Affected Districts: All)

(Presenter: Virginia Hastings, Executive Director, 388-5823)

BACKGROUND INFORMATION

Approval of this item will allow the Inland Counties Emergency Medical Agency (ICEMA) to establish fees for Fiscal Year (FY) 2010-11.

ICEMA is a Joint Powers Authority and as such, presents fees separately from other County departments. ICEMA is the local Emergency Medical Services (EMS) Agency for the Counties of San Bernardino, Inyo, and Mono. ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective emergency medical services system including pre-hospital providers, specialty care hospitals and hospitals.

This early adoption date for fees allows for the adoption of fees to occur prior to the development of the proposed budget, and for the fees to become effective at the beginning of the new fiscal year (July 1). Additionally, it allows ICEMA to calculate any rate adjustments into their FY 2010-11 budget request to ensure that they sufficiently accommodate all costs associated with those activities.

ICEMA's proposed fees represent the estimated cost of providing various services. ICEMA has submitted to the County Administrative Office detailed information of its fee recommendations to provide the Board of Directors with the necessary information to adopt the fee schedule for FY 2010-11. The fees proposed for the upcoming fiscal year include anticipated salaries and benefits increases, and inflationary adjustments for services provided. In accordance with Government Code Section 66016, a public hearing must be conducted prior to approval of fees. The effective date of ICEMA's fee policy will be July 1, 2010.

During the rate review process, and under advice of County Counsel, the rate setting authority is



being separated and implemented as an ICEMA Fee Schedule Policy. It was determined that ICEMA's fee schedule be adopted through policy to reflect organizational changes within the County, and to reflect that ICEMA is a Joint Powers Agency with oversight by a Governing Board.

FINANCIAL IMPACT

Approval of this item imposes no additional cost to the County. If approved, the total anticipated increase to fee revenue is \$33,696 over the current year. This increase is necessary in order to accommodate anticipated increases in salaries and benefits, and any inflationary costs for operations.

REVIEW BY OTHERS

This item has been reviewed by County Counsel (Alan Green, Deputy County Counsel, 387-5288) on **April 29, 2010** and the County Administrative Office (Trudy Raymundo, Administrative Analyst, 387-3986) on **May 10, 2010**.



2010/2011 FEE SCHEDULE

PURPOSE

To establish the ICEMA fee schedule for 2010/2011.

PROCEDURE

ADMINISTRATION

1. Transportation
 - A. Annual EMS pre-hospital provider permit/authorization\$1,570.00
 - B. Annual EMS pre-hospital provider permit/authorization
Late penalty\$315.00
 - C. Annual EMS Aircraft Provider\$15,000.00
 - D. Annual EMS Drug and Equipment Inspection.....\$315.00/unit
2. EMS Certification Fees
 - A. Mobile Intensive Care Nurse (MICN)
 1. Certification.....\$90.00
 2. Recertification.....\$90.00
 3. Challenge.....\$225.00
 - B. Emergency Medical Technician – Paramedic (EMT-P)
 1. Accreditation.....\$80.00
 2. Re-verification.....\$40.00
 - C. Emergency Medical Technician (EMT)
 1. Certification.....\$32.00

2.	Recertification.....	\$32.00
3.	Challenge.....	\$225.00
D.	Emergency Medical Services Dispatchers	
1.	Certification.....	\$32.00
2.	Recertification.....	\$32.00
3.	Challenge.....	\$60.00
E.	Emergency Medical Responders	
1.	Certification.....	\$32.00
2.	Recertification	\$32.00
3.	Challenge	\$75.00
F.	Accreditation/Certification Re-test	\$53.00
G.	Certification/Accreditation card replacement.....	\$20.00
H.	Certification/Accreditation card name change.....	\$20.00
3.	Training Program Approval	
A.	MICN.....	\$300.00
B.	EMT.....	\$575.00
C.	EMT-P.....	\$1,000.00
D.	Annual Review Curriculum Instruction.....	\$300.00
E.	Emergency Medical Responders.....	\$200.00
F.	Continuing Education Provider approval	\$221.00
4.	Hospitals	
A.	Base hospital application.....	\$2,500.00

- B. Base hospital bi-annual re-designation.....\$525.00
- C. Trauma hospital application fee.....\$5,000.00
- D. Trauma hospital annual re-designation\$25,000.00
- E. Cardiac center application fee\$5,000.00
- 5. EMS Temporary Special Events
 - A. Minor event application\$75.00
 - B. Major event application\$315.00
- 6. Protocol Manual
 - A. With binder\$26.00
 - B. Inserts only\$15.00
- 7. Equipment Rental
 - A. Standard Equipment.....\$10.00/item
 - B. Deluxe Equipment\$25.00/item
- 8. Statistical Research.....\$50.00/hour

SECTION 2. This rate schedule shall take effect July 1, 2010.



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

*Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director*

DATE: March 24, 2010
TO: All ALS Providers
FROM: Reza Vaezazizi MD
Medical Director
[Handwritten Signature]
SUBJECT: NASAL ADMINISTRATION OF MEDICATIONS

Nasal administration of medication via the Mucosal Atomizer Device (MAD), was approved by the Medical Advisory Committee in January. It was agreed upon to add this route of medication administration to the existing protocols that are affected as opposed to writing a separate policy. Listed below are the protocols that will have this change effective July 1st, 2010.

- 7010 Standard Drug and Equipment List
- 7020 EMS Standard Drug and Equipment List
- 10110 Transcutaneous Cardiac Pacing
- 10120 Synchronized Cardioversion
- 11060 Suspected Acute MI
- 11080 ALOC Adult
- 11100 Burns Adult
- 13030 Cold Related Emergencies
- 14050 ALOC Peds
- 14060 Seizures
- 14070 Burns Peds
- 15010 Trauma Adult
- 15020 Trauma Peds

Please feel free to contact Sherri Shimshy RN, EMS Nurse Specialist with any questions SShimshy@cao.sbcounty.gov or (909) 388-5816.

VH/jch

Enclosure



BLS/ALS STANDARD DRUG & EQUIPMENT LIST

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

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

MEDICATIONS/SOLUTIONS

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

Exchanged Medications/Solutions	BLS	ALS Non-Transport	ALS Transport
Normal Saline 100cc		1	2
Normal Saline 250cc		1	1
Normal Saline 1000cc		3	6
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)		4	4
Ondansetron (Zofran) 4 mg IM/ IV		4	4
Phenylephrine HCL - 0.5mg per metered dose		1 bottle	1 bottle
Procainamide 1 gm		1	2
Sodium Bicarbonate 50 mEq preload		2	2
Verapamil 5 mg		3	3

CONTROLLED SUBSTANCE MEDICATIONS

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

AIRWAY/SUCTION EQUIPMENT

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

Exchanged Airway/Suction Equipment	BLS	ALS Non-Transport	ALS Transport
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr		1 each	1 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Needle Cricothyrotomy Device – Pediatric and adult or Needles for procedure 10ga, 12ga, 14ga, 15ga		1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent		1	1
Oropharyngeal Airways – (infant, child, and adult)	1 each	1 each	1 each
Pediatric non-rebreather O2 mask	2	2	2
Small volume nebulizer with universal cuff adaptor		2	2
Suction Canister 1200 cc	1	1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each	1 each	1 each
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent) Adult	1 each 1 each	1 each 1 each	1 each 1 each
Water soluble lubricating jelly		1	1
Yaunkers tonsil tip	1	1	1

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

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

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

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	ALS Non-Transport	ALS Transport
OSHA approved single use lancets			
EZ-IO Needles – Pts. 40kg or greater: 25mm, 15 gauge		2 each	2 each
Pts. 3-39 kg: 15mm, 15 gauge		1 each	1 each
LD needle		1	1
3-way stopcock with extension tubing		2	2
IO Needles - sizes 16, 18, 20 gauge		1 each	1 each
IV Catheters – sizes 14, 16, 18, 20, 22, 24		2 each	2 each
Microdrip Administration Set (60 drops/cc)		1	2
Macro drip Administration Set (10 drops/cc)		3	3
<u>Mucosal Atomizer Device (MAD) for nasal administration of medication</u>		4	4
Pressure Infusion Bag (disposable)		1	1
Razors		2	2
Safety Needles – 20 or 21 gauge and 23 or 25 gauge		2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2
Sterile IV dressing		2	2
Syringes w/wo safety needles – 1cc, 3cc, 10cc, 20cc, 60cc catheter tip		2 each	2 each

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

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	ALS Non-Transport	ALS Transport
AED/defib pads	2		
Ammonia Inhalants		2	2
Approved Automatic ventilator		1	1
Backboard padding	1	1	1
Bone Injection Drill (adult and pediatric) or ICEMA		2	2

Non-Exchange Optional Equipment/Medications	BLS	ALS Non-Transport	ALS Transport
approved IO device			
Buretrol		1	1
Chemistry profile tubes		3	3
Gum Elastic intubation stylet		2	2
IV infusion pump		1	1
IV warming device		1	1
Manual IV Flow Rate Control Device			
Manual powered suction device	1	1	1
Multi-lumen peripheral catheter		2	2
Needle Thoracostomy Kit (prepackaged)		2	2
Pitocin		20 units	20 units
Translaryngeal Jet Ventilation Device		1	1
Vacutainer		1	1

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

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

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



EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	Amount
Adenosine (Adenocard) 6mg	30mg
Adrenaline (Epinephrine) 1:1,000	2mg
Adrenaline (Epinephrine) 1:10,000	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg	2 doses
Aspirin, chewable - 81mg tablet	1bottle
Atropine 1mg preload	3mg
Calcium Chloride	1gm
Dextrose 25%	50gm
Dextrose 50%	50gm
Diphenhydramine (Benadryl) 50mg	50mg
Furosemide (Lasix)	40mg
Glucagon	1mg
Intropin (Dopamine)	200mg
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Lidocaine	300mg
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250cc D5W	2gm
Lidocaine 2% (Viscous)	2oz
Magnesium Sulfate 10mg	10gms
Naloxone (Narcan)	10mg
Nitroglycerin – Spray 0.4 mg metered dose	1
Normal Saline for Injection (10cc)	2
Normal Saline 250ml	1
Normal Saline 1000ml	4
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5mg per metered dose	1bottle
Procainamide	1gm
Sodium Bicarbonate	100mEq

Exchanged Medications/Solutions	Amount
Verapamil (Isoptin)	15mg

CONTROLLED SUBSTANCE MEDICATIONS

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

AIRWAY/SUCTION EQUIPMENT

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

Durable Items IV/Needles/Syringes/Monitoring Equipment	Amount
Thermometer	1

OPTIONAL EQUIPMENT/MEDICATIONS

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

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Single Use Dressing Materials/Other Equipment Supplies	Amount
Adhesive tape – 1 inch	2
Air occlusive dressing (Vaseline gauze)	1
Ankle & wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Cervical Collars – Rigid Pediatric & Adult <i>or</i>	2 each
Cervical Collars – Adjustable Adult & Pediatric	2 each
Emesis basin or disposable bags & covered waste container	1
Head immobilization device	2
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4
Provoidine/Iodine swabs/wipes	
Roller bandages – 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads – 4x4 inch	4

Single Use Dressing Materials/Other Equipment Supplies	Amount
Sterile Sheet for Burns	2
Universal Dressing 10x30 inches	2

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



TRANSCUTANEOUS CARDIAC PACING

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Symptomatic Bradycardia - see Protocol Reference #11040 Adult Bradycardia.
2. Witnessed asystole - see Protocol Reference #11070 Adult Cardiac Arrest.
3. Patient 8 years of age and younger - **not indicated**.

PROCEDURE IN SYMPTOMATIC BRADYCARDIA

1. Start at rate of 60 and adjust the output control starting at 0 milli amperes until capture is noted. Assess peripheral pulses and confirm correlation with paced rhythm.
2. Determine lowest threshold response by turning the output control down, until capture is lost, and then turn it back up slightly until capture is noted again. Maintain the output control at this level.
3. Assess peripheral pulses and confirm correlation with paced rhythm. Reassess patient for signs of adequate perfusion
4. Any movement of patient may increase the capture threshold response; the output may have to be adjusted to compensate for loss of capture.
5. With signs of inadequate tissue perfusion, increase rate (**not to exceed 100**) and contact Base Station.
6. Consider Midazolam 1-2 mg slow IV push or 1-2 mg IN if patient is awake and alert.
7. Consider Morphine Sulfate titrate in 1-2mg increments up to 10mg for patient complaint of pain with signs of adequate tissue perfusion.
8. Contact Base Station to advise of patient condition

PROCEDURE IN ASYSTOLE

1. Start at maximum energy output on the pacing device.
2. Follow above procedures #2-4.
3. If pacing is ineffective, contact Base Station and consider termination of

resuscitative efforts.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, an Incident Report must be completed by the receiving hospital and forwarded to ICEMA within 24 hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.



SYNCHRONIZED CARDIOVERSION

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Unstable V-Tach or Wide Complex Tachycardias (sustained).
2. Unstable Narrow Complex Tachycardias.
3. Patient 8 years of age and younger - **not indicated**.

PROCEDURE

1. Monitor the patient in a lead that maximizes upright R wave and minimizes T wave, and observe location of synchronized marker on the R wave.
2. Consider Midazolam 1-2 mg slow IV push or 1-2mg IN for all conscious patients.
3. Consider Morphine Sulfate titrated in 1-2mg increments up to 10mg slow IV push for patient complaint of pain with signs of adequate tissue perfusion.
4. Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines.
5. Procedure may be repeated at 200, 300 & 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.
6. If cardioversion is successful, continue to monitor the patient and refer to the appropriate corresponding protocol.
7. In Radio Communication failure or with Base Station order, repeated cardioversion attempts at 360 joules or a clinically equivalent biphasic energy level per manufacture's guidelines may be attempted.
8. If ventricular fibrillation should occur during preparation or following cardioversion, immediately:
 - a. Turn off synchronizer and check pulse.
 - b. Charge unit to 200 - 360 joules, or clinically equivalent biphasic energy level per manufacture guidelines.

- c. Defibrillate per the appropriate corresponding protocol.
9. Document all reassessments of rhythm and pulses.



ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Patient exhibiting signs/symptoms of a possible altered level of consciousness.
2. Suspected narcotic dependence, overdose, hypoglycemia, traumatic injury, shock and alcoholism.
3. Tonic/clonic movements followed by a brief period of unconsciousness (post-ictal).
4. Suspect status epilepticus for frequent or extended seizures.

BLS INTERVENTIONS

1. Oxygen therapy as clinically indicated.
2. Position patient as tolerated. If altered gag reflex in absence of traumatic injury, place in left lateral position.
3. Place patient in axial spinal stabilization if trauma is suspected.
4. If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

ALS INTERVENTIONS

1. Obtain vascular access and place on monitor.
2. Obtain blood glucose If hypoglycemic administer:
 - a. Dextrose 25 Grams (50cc) IV/IO of 50% solution, or
 - b. Glucagon 1mg IM/SC/IN, if unable to establish IV. May give one (1) time only.
 - c. May repeat blood glucose. Repeat Dextrose if extended transport time.

3. For tonic/clonic type seizure activity administer:
 - a. Midazolam 5-10mg IM or 2.5-5mg IV/IO/IN.
 - b. Repeat Midazolam for extended or recurrent seizure activity.
4. If suspected narcotic overdose administer:
 - a. Naloxone 2mg IV/IM/IN.
 - b. Repeat Naloxone 2mg IV/IM/IN every 2-3 minutes if needed.
5. Assess and document response to therapy.
6. Base Station may order additional medication dosages and fluid bolus.



ALTERED LEVEL OF CONSCIOUSNESS - PEDIATRIC (Less than 15 years of age)

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Patient exhibits inappropriate behavior for age.
2. History or observation of an Apparent Life Threatening Event.

BLS INTERVENTIONS

1. Assess environment and determine possible causes for illness.
2. Axial-spinal stabilization, if clinically indicated.
3. Oxygen therapy as clinically indicated.
4. Airway management as indicated (OPA/NPA, BVM Ventilation).
5. Obtain core temperature, if elevated begin passive cooling measures.

ALS INTERVENTIONS

1. Establish advanced airway as needed.
2. Obtain vascular access and place on cardiac monitor.
3. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20ml/kg of NS not to exceed 300ml NS.
4. Check blood glucose level.
 - a. For pt. < 10 kg if glucose less than 60 mg/DL:
Dextrose 25% 0.5 Gm/kg (2ml/kg) IO/IV
 - b. For pt. >10 kg but less than 25kg if glucose less than 60mg/DL:
Dextrose 50% 0.5 Gm/kg diluted 1: 1 (2ml/kg)
 - c. For pt. > 25 kg if glucose less than 80mg/DL:
Dextrose 50% 0.5 Gm/kg diluted 1: 1 (2ml/kg)

- d. If unable to establish IV, may give Glucagon 0.025 mg/kg IM/IN, may be repeated 1 time after 20 minutes for a combined maximum dose of 1 mg.
- 5. For suspected narcotic ingestion, may give Narcan 0.1 mg/kg IV/IM/IN. Do not exceed the adult dosage of 2mg IV/IM/IN.
- 6. Base Station may order additional medication dosages and additional fluid boluses.



SEIZURE - PEDIATRIC (Less than 15 years of age)

FIELD ASSESSMENT/TREATMENT INDICATORS

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

BLS INTERVENTIONS

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

ALS INTERVENTIONS

1. Establish advanced airway as needed.
2. Obtain vascular access and place on cardiac monitor if indicated.
3. If clinically indicated, obtain a Blood Glucose level and provide treatment.

4. For seizure activity, administer Midazolam 0.2 mg/kg IM/IN with maximum IM dose of 10 mg or 0.1 mg/kg IV/IO with maximum dose 2.5-5 mg IV/IO. Repeat Midazolam if necessary not to exceed adult dosage
5. Assess and document response to therapy.
6. Base Station may order additional medication dosages or a fluid bolus.



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director

DATE: March 23, 2010

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Reza Vaezazizi, M.D. *Reza Vaezazizi, MD* Virginia Hastings
ICEMA Medical Director ICEMA Executive Director *Virginia Hastings*

SUBJECT: PROTOCOLS FOR 45 DAY COMMENT

The following eight (8) protocols have been reviewed and revised by the Protocol Education Committee and are now available for public comment and recommendations. ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until Friday, May 14th, 2010 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to SShimshy@cao.sbcounty.gov. Comments submitted and any revisions made will be presented at the May 20, 2010 Emergency Medical Care Committee (EMCC) meetings held in all three counties.

Protocol

Reference #:

- 1050 MICN Certification Requirements - ADDITION of the Administrative MICN
- 1080 Flight Nurse Authorization - NEW
- 6050 Pulse Oximetry Service Provider Requirement - DELETE
- 6080 Paramedic Blood Draw for Chemical Testing At the Request of a Peace Officer - NEW
- 8010 Interfacility Transfer Guidelines - Major rewrite
- 9020 Physician on Scene - ADDITION of signature page in the electronic patient care record
- 9040 Reporting Incidents of Suspected Abuse - ADDITION of Ombudsman Information
- 9050 Organ Donor Information - UPDATED information on California Donor Registry

RV/VH/DWS/SS/mae

Attachments: (8) Protocols, List of Changes & Protocol Comments Form

July 1, 2010
Policy, Procedure
and Protocol Manual Changes

Policy #	Title	Changes/Comments
1000 ACCREDITATION AND CERTIFICATION		
1050	MICN	Addition of the administrative MICN. Removed the testing requirement for the the inactive MICN
1080	Flight Nurse Authorization Requirements	New Policy
2000 DATA COLLECTION		
3000 EDUCATION		
4000 QUALITY IMPROVEMENT		
5000 MISCELLANEOUS SYSTEM POLICIES		
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
6050	Pulse Ox Provider	Removal of this policy. Will be standard scope of practice for EMT's as of July 1, 2010
6050	Paramedic Blood Draw Program	New Specialty program.
7000 STANDARD DRUG & EQUIPMENT LISTS		
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		
8010	Interfacility Transfer Guidelines	Major revisions please review all sections.

July 1, 2010
Policy, Procedure
and Protocol Manual Changes

Policy #	Title	Changes/Comments
9000 GENERAL PATIENT CARE POLICIES		
9020	Physician on Scene	Addition of ability to document on ePCR.
9040	Reporting Incidents of Suspected Abuse	Addition of Ombudsman information
9050	Organ donation	Updated information about California Donor registry
10000 SKILLS		
11000 ADULT EMERGENCIES		
12000 END OF LIFE CARE		
13000 ENVIRONMENTAL EMERGENCIES		
14000 PEDIATRIC EMERGENCIES		
15000 TRAUMA		
POLICY DELETIONS		
6050	Pulse Ox Provider	Removal of this policy. Will be standard scope of practice for EMT's as of July 1, 2010



MICN CERTIFICATION REQUIREMENTS

PURPOSE

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

PROCEDURE

Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
 - a. Fee as set by ICEMA. The fee is not refundable or transferable.
 - b. Written verification of employment at a designated Base Hospital within the ICEMA Region.
 - c. Copy of front and back of a current, signed ACLS Card.
 - d. Copy of front and back of current California RN License.
3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.
5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.
 - a. A candidate who fails to pass the ICEMA 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 Hospital MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.
7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
9. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Continuous MICN Certification

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

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

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

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 Hospital within the ICEMA Region.

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

2. A provisional MICN may function under the direct supervision of the Base Hospital MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.
4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Hospital PLN for review.
5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
6. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Certification by Challenge Examination

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
 - a. MICN in another county within previous twelve (12) months
 - b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status
3. Submit the appropriate ICEMA application with:

- a. Fee as set by ICEMA.
 - b. Written verification of employment at a designated Base Hospital within the ICEMA Region.
 - c. Copy of front and back of a current, signed ACLS Card.
 - d. Copy of front and back of current California RN License.
4. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
 5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA 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 Hospital MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.
 8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
 9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
 10. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

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 2b through 2g under Initial Certification above
- b. Must submit proof of employment with an approved non base station employer.
- c. Must teach or attend an additional skills day
- d. Must teach or attend an additional 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 hospital or another approved non base hospital employer.

This certification may be converted to regular MICN status upon written verification of employment at a designated Base Hospital 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 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.
6. Proof of attendance of four (4) hour Flight Nurse Orientation course.
7. Successfully pass the local authorization written examination with a minimum score of eighty percent (80%).
 - a. A candidate who fails to pass the local authorization written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a minimum score of 85%.
 - b. A candidate who fails to pass the ICEMA local authorization written examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies I procedures given by their EMS/QI

Coordinator and pass the local authorization written examination with a minimum score of 85%.

- c. If the candidate fails to pass the local authorization written examination on the third attempt, the individual will be ineligible to retest for a period of six (6) months.

REAUTHORIZATION

Flight Nurse Reauthorization Submit application 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.
6. Proof of attendance of four (4) hour Flight Nurse Orientation course.



PULSE OXIMETRY SERVICE PROVIDER REQUIREMENTS

PURPOSE

To establish a standard mechanism for approval and designation of an EMT-I Pulse Oximetry service provider.

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.

PROCEDURE

Provider agencies seeking approval shall submit the following to ICEMA prior to beginning service:

1. A statement agreeing to comply with all of ICEMA protocols and procedures related to the program.
2. Identify the individual responsible for managing the program (program coordinator).
3. Policies and procedures to ensure orientation and continued competency of designated personnel.
4. Identify the CQI program including the methods used to review.
5. Anticipated number of personnel to be trained.
6. Agree to follow approved ICEMA curriculum or submit curriculum for review and approval by ICEMA.

RECORD KEEPING

Pulse Oximetry readings shall be documented on the Patient Care Record (OIA).

REMOVE ----- STANDARD SCOPE OF PRACTICE



PARAMEDIC BLOOD DRAW FOR CHEMICAL TESTING AT THE REQUEST OF A PEACE OFFICER

Specialty Program

PURPOSE

To allow ICEMA accredited paramedics, not employed by fire departments, to withdraw blood samples at the request of a sworn peace officer for the purpose of chemical testing from persons suspected of driving under the influence.

Per California Vehicle Code 23158 (k): paramedics employed by fire departments are not allowed to draw blood for a peace officer.

AUTHORITY

Title 22; Division 9, Chapter 4, Section 100145.

Vehicle Code Section 23158

Vehicle Code section 23158, sub. (d),

Notwithstanding any other provision of law, no . . . certified paramedic . . . shall incur any civil or criminal liability as a result of the administering of a blood test in a reasonable manner in a hospital, clinical laboratory, medical clinic environment, jail, or law enforcement facility, according to accepted venipuncture practices, without violence by the person administering the test, and when requested in writing by a peace officer to administer the test.

POLICY

Upon completion of an agreement with the employing ALS agency and with the approval of ICEMA, allow paramedics to draw blood at the request of law enforcement for chemical testing.

At no time will the request for blood draw for alcohol level take precedence over the medical treatment of the patient.

PROCEDURE

An EMT-P, at the request of law enforcement, may draw blood for chemical testing if the following conditions are met:

1. The employing ALS agency received ICEMA approval following submittal for a Specialty/Optional Scope Program to draw blood at the request of law enforcement.

2. The request must be in writing from the Peace Officer.
3. Blood Draw Kits will be supplied by the law enforcement agency.
4. The procedure will be performed based on standard practice, pursuant to the directions on the supplied kit (benzalkonium chloride) and documented as such. The obtained sample will be the property of the arresting officer.
5. A patient care record must be completed for all requests and include, at a minimum, the following information:
 - a. Patient name
 - b. Sex
 - c. Date and time
 - d. Name of requesting Peace Officer
 - e. Brief medical history including medications and allergies
 - f. Vital signs
 - g. Brief narrative including the kit number, skin preparation used, and location of the blood draw.
 - h. If a second needle stick is required, the site and skin preparation will be documented.
 - i. The patient's consent for the procedure and the Peace Officer's request for the procedure will also be documented with the name and badge number of the Peace Officer.
6. Base Station contact is not required unless there is a medical necessity

Contraindications

1. Patient history of an allergy to the antiseptic used in the Kit, or to Betadine. The EMT-P must refuse the request to draw and inform the Peace Officer of the situation.
2. If the patient is on anti-coagulant therapy, direct pressure will be held on the site for at least one (1) full minute. A pressure dressing will be applied.

3. No blood draws will be performed on patients with hemophilia.
4. No blood draws will be performed on combative persons.
5. If the patient refuses the blood draw for any reason, the paramedic will document and stop procedure immediately. The medic is not allowed to draw blood on a struggling or restrained patient. The patient must be cooperative.

Training

Paramedics will be required to participate in a training program focusing on proper preparation of the blood draw site and required documentation.

Additional documentation:

1. A log will be kept of all blood draws for DUI by the paramedic employer for QI purposes.
2. The EMT-P should provide his or her name and any other information needed to complete the *Blood Draw Request Form* from the law enforcement agency.

APPROVED

ICEMA Medical Director Date

ICEMA Executive Director Date

Inyo Co. Health Officer Date

Mono Co. Health Officer Date

San Bernardino Co. Health Officer Date



INTERFACILITY TRANSFER GUIDELINES

PURPOSE

To identify patient care responsibilities for EMT-Is and EMT-Ps during interfacility transports.

AUTHORITY

Title 22, Division 2.5, Sections 1797.214, 1798.170 and 1798.172 of the California Health and Safety Code

BLS POLICY

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

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

1. Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
 - a. No medications have been added to the IV fluid.
 - b. Maintain the IV at a pre-set rate.
 - c. Check tubing for kinks and reposition arm if necessary.
 - d. Turn off IV fluid if signs/symptoms of infiltration occur.
 - e. Control any bleeding at insertion site.
2. Transport a patient with a Foley catheter provided:
 - a. The catheter is able to drain freely.
 - b. No action is taken to impede flow or contents of drainage collection bag.

3. Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped
4. If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital

ALS POLICY

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

If the transfer is for a STEMI patient please refer to Policy #8040 Interfacility Transfer of STEMI Patient

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

Paramedics may not transport patients with blood or blood products

During an interfacility transport, an ICEMA Accredited EMT-P or supervised EMT-P intern may:

1. Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water
2. Transport intravenous solutions with added medication (s) as follows:
 - a. Lidocaine
 - b. Dopamine
 - c. Procainamide
 - d. Magnesium Sulfate
 - e. Pitocin
3. Monitor and administer medications through a pre-existing vascular access.
4. Monitor heparin lock or saline lock.

5. Monitor IV solutions containing potassium $\leq 40\text{mEq/L}$.
6. Monitor thoracostomy tubes to water sealed drainage.
7. Monitor nasogastric tubes.
8. Paramedics may initiate prior to contact protocols if the patient's condition deteriorates then must contact the Base Hospital per protocol #5010 Radio Communication Policy.

NURSE ASSISTED ALS TRANSPORT

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



PHYSICIAN ON SCENE

PURPOSE

To establish criteria for an EMT-Paramedic during situations in which a physician is physically present at the scene of a 9-1-1 response.

AUTHORITY

Division 9, Chapter 4, Article 2, Section 100147 and Article 8, Section 100175 of the California Code of Regulations.

POLICY

Medical responsibility for patient care is the responsibility of the Base Station physician. Within the ICEMA Region, an EMT-P may only follow medical orders given by the Base Station physician or MICN

PROCEDURE

In the event that an EMT-P arrives at the scene of a medical or a trauma emergency and a physician on scene wishes to direct the care of the patient and assume medical responsibility for the patient, the following conditions apply:

1. The physician must be informed that Base Station contact must be made, and the final decision regarding the assumption of medical responsibility for patient care will be made by the Base Station physician.
2. The physician must show proper identification and a current California physician's license.
3. The physician must agree to sign the patient care record agreeing to take full responsibility for the care and treatment of the patient(s) involved in the incident and accompany the patient(s) in the ambulance to the medical facility most appropriate to receive the patient(s). This statement is available on the ICEMA e-PCR and on the back of the first (white) copy of the ICEMA Standard Run Report Form (01A). Prehospital EMS agencies using software not totally integrated with ICEMA software must provide a form stating the above and obtaining physician signature.
4. Care of the patient must be transferred to a physician at the receiving facility.

EMT-P RESPONSIBILITIES

The EMT-P has the following responsibilities in the event that the physician on scene assumes responsibility for patient care:

1. Notify Base Hospital that a physician is taking charge of the patient(s)
2. Maintain control of drugs and equipment from the ALS unit. Inform the physician of drugs and equipment available.
3. Offer assistance to the physician on scene. The EMT-P may only perform procedures that are within the ICEMA scope of practice.
4. Document on patient care record all necessary information and obtain physician signature.



REPORTING INCIDENTS OF SUSPECTED ABUSE POLICY

Prehospital personnel are required to report incidents of suspected neglect or abusive behavior towards children, dependant adults or elders. These reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report.

When two or more persons who are required to report are present at scene, and jointly have knowledge of a suspected abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

Information given to hospital personnel does not fulfill the required reporting mandated from the state. The prehospital caregivers must make their own report.

CHILD ABUSE/NEGLECT

Suspicion of Child abuse/neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline immediately or as soon as possible. Be prepared to give the following information:

1. Name of person making report.
2. Name of child.
3. Present location of child.
4. Nature and extent of the abuse/neglect.
5. Location where incident occurred, if known.
6. Other information as requested.

San Bernardino County: 1-800-827-8724 24-hour number **or** 1-909-384-9233

Inyo County: 1-760-872-1727 M-F 8 am - 5 pm **or** 911 after hours

Mono County: 1-800-340-5411 M-F 8 am - 5 pm **or** 1-760-932-7755 after hours

The phone report must be followed within 36 hours by a written report on the “**Suspected Child Abuse Report**” form. Mail this to:

San Bernardino County: CPS
412 W. Hospitality Lane
San Bernardino, CA 92408

Inyo County: CPS
162 Grove St. Suite “J”
Bishop, Ca. 93514

Mono County Department of Social Services
PO Box 576
Bridgeport, Ca. 93517

The identity of any person who files a report shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protection agency, or to the district attorney in a criminal prose.

DEPENDENT ADULT AND ELDER ABUSE/NEGLECT

Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by telephone. Be prepared to give the following information:

1. Name of person making report.
2. Name, address and age of the dependent adult or elder.
3. Nature and extent of person’s condition.
4. Other information, including information that led the reporter to suspect either abuse or neglect.

San Bernardino County: 1-877-565-2020 24-hour number

Inyo County: 1-760-872-1727 M-F 8 am - 5 pm or 911 after hours

Mono County: 1-800-340-5411 M-F 8 am - 5 pm or 1-760-932-7755 after hours

The phone report must be followed by a written report within 48 hours of the telephone report on the “**Report of Suspected Dependent Adult/Elder Abuse**” form. Mail this report to:

San Bernardino County: Department of Aging/Adult Services
881 West Redlands Blvd. *Attn:* Central Intake
Redlands, CA 92373
Fax number 1-909-388-6718

Inyo County: Social Services
162 Grove St. Suite "J"
Bishop, Ca. 93514

Mono County: Department of Social Services
PO Box 576
Bridgeport, Ca. 93517

The identity of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.

San Bernardino County Department of Aging and Adult Services Long-Term Care Ombudsman Program

Ombudsmen are independent, trained and certified advocates for residents living in long-term care facilities. Certified Ombudsmen are authorized by Federal and State law to receive, investigate and resolve complaints made by or on behalf of residents living in skilled nursing or assisted living facilities for the elderly. Ombudsmen work with licensing and other regulatory agencies to support Resident Rights and achieve the best possible quality of life for all long-term care residents. Ombudsman services are confidential and free of charge.

Administrative Office
Receives All Reports of Abuse
686 E. Mill St.
San Bernardino, Ca 92415-0640
909-891-3928 Office
1-866-229-0284 Reporting
Fax 909-891-3957

The State CRISISline number:

1-800-231-4024

This CRISIS line is available to take calls and refer complaints 24 hours a day, 7 days a week.



ORGAN DONOR INFORMATION

PURPOSE

To comply with state legislation requiring emergency medical services (EMS) field personnel to search for organ donor information on adult patients for whom death appears imminent.

AUTHORITY

California Health and Safety Code, Section 7152.5, b (3) and c, d and e

DEFINITIONS

Reasonable Search: A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver's license or other identification card with this information. A reasonable search shall not take precedence over patient care/treatment.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at the receiving hospital.

POLICY

Existing law provides that any individual who is at least eighteen (18) years of age may make an anatomical gift and sets forth procedures for making that anatomical gift, including the presence of a pink dot on their drivers license indicating enrollment in the California Organ and Tissue Donor Registry.

1. When EMS field personnel encounter an unconscious adult patient for whom it appears death is imminent, a reasonable search of the patient's belonging should be made to determine if the individual carries information indicating status as an organ donor. This search shall not interfere with patient care or transport. Any inventory of victim's personal effects should be on the patient care record and signed by the person who receives the patient.
2. All EMS field personnel shall notify the receiving hospital if organ donor information is discovered.

3. Any organ donor document discovered should be transported to the receiving hospital with the patient unless the investigating law enforcement officer requests the document. In the event that no transport is made, any document should remain with the patient.
4. EMS field personnel should briefly note the results of the search, notification of hospital and witness name(s) on the patient care report.
5. No search is to be made by field personnel after the patient has expired.

DRAFT

45 Day Comment Period for Protocols
 March 31 thru May 14, 2010

PROTOCOL #	AGENCY	COMMENT	RESPONSE
All	Ontario Airport	None	
8010	Big Bear City Fire	Nurse Assisted ALS Transport – Person responsible for overall patient care is not clearly defined. If the nurse is not an MICN, does the paramedic assume the lead role in the event immediate ALS care is needed? (Such as intubation or Cardioversion) or after base hospital contact has been established?	Clarify through education the role of the transport nurse vs the paramedic.
1050	Marie Podboy	MICN Challenge - is this available for MICNs who are employed by a "non base station" (3b indicates only employment by a Base Hospital) also?	MICN Challenge doesn't apply to the Administrative RN
6080		Does the patient care record have to be a separate record from the one being used for other documentation, or may the blood draw be entered on the same PCR?	Maybe the same PCR for a patient
6080		PROCEDURE 5i has a typo - reads "Peach Officer" instead of "Peace Officer"	Correct
8010		Could we add "monitor saline or heparin lock" to the EMT-1 scope of transport?	Yes
1080	Mercy Air By Frankie Meneses	Hospital sending an ED nurse should consider liability issues for the hospital. Please consider the lack of familiarity with the equipment, transport vehicle and patient safety practices for ground transport. To follow the established standard locally for transport RN's please consider adding the following requirements to Flight RN Valid State RN licensure	Nurse should have a go bag for transports (hospital education) These are requirements of the hiring agency our program is for orientation into the ICEMA region

