AGENDA

ICEMA
MEDICAL ADVISORY COMMITTEE

February 23, 2023

1300

Purpose: Information Sharing
Meeting Facilitator: Seth Dukes
Timekeeper: Michelle Hatfield
Record Keeper: Michelle Hatfield

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PERSON(S)</th>
<th>DISCUSSION/ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Welcome/Introductions</td>
<td>Seth Dukes</td>
<td></td>
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<tr>
<td>II. Approval of Minutes</td>
<td>All</td>
<td>Discussion</td>
</tr>
<tr>
<td>III. Discussion/Action Items</td>
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<td></td>
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<tr>
<td>A. Standing EMS System Updates</td>
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<tr>
<td>1. Trauma Program</td>
<td>Loreen Gutierrez</td>
<td>1. Discussion</td>
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<tr>
<td>2. STEMI Program</td>
<td>Loreen Gutierrez</td>
<td>2. Discussion</td>
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<tr>
<td>3. Stroke Program</td>
<td>Loreen Gutierrez</td>
<td>3. Discussion</td>
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<tr>
<td>B. HEMS Utilization Task Force</td>
<td>Stephen Patterson</td>
<td>Discussion</td>
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<tr>
<td>C. Prehospital Ultrasound Trial Study Update</td>
<td>Michael Neeki</td>
<td>Discussion</td>
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<tr>
<td>D. Mono/Inyo County Updates</td>
<td>Lisa Davis/Jessica Wagner</td>
<td>Discussion/Action</td>
</tr>
<tr>
<td>E. New Chair/Member Endorsements</td>
<td>Loreen Gutierrez</td>
<td>Discussion/Action</td>
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<tr>
<td>F. Protocol Review</td>
<td>Loreen Gutierrez/ Michelle Hatfield</td>
<td>Discussion/Action</td>
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<tr>
<td>Policy and Protocol Manual Update 8050 - Requests for Hospital Diversion and Ambulance Redirection 8100 - Ambulance Patient Offload Delay (APOD)</td>
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<tr>
<td>IV. Public Comment Period</td>
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<td>Discussion</td>
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<tr>
<td>V. Future Agenda Items</td>
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<td>Discussion</td>
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<tr>
<td>VI. Next Meeting Date: April 27, 2023</td>
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<td>Discussion</td>
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<tr>
<td>VII. Adjournment</td>
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<td>Action</td>
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<tr>
<td>VIII. Closed Session Case Review</td>
<td>MAC Committee</td>
<td>Discussion/Action</td>
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<tr>
<td>A. Loop Closure Cases</td>
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<tr>
<td>B. Case Reviews</td>
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### MINUTES

#### ICEMA

**MEDICAL ADVISORY COMMITTEE**

**December 15, 2022**

1300

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION/FOLLOW UP</th>
<th>RESPONSIBLE PERSON(S)</th>
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</thead>
<tbody>
<tr>
<td>I. Welcome/Introductions</td>
<td>Meeting was called to order at 1301</td>
<td>Seth Dukes</td>
</tr>
<tr>
<td>II. Approval of Minutes</td>
<td>The October 27, 2022, minutes were approved. Motion to approve. MSC: Michael Neeki/Susie Moss APPROVED AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
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<tr>
<td>III. Discussion/Action Items</td>
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<tr>
<td>A. Standing EMS System Updates</td>
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<tr>
<td>1. Trauma Program</td>
<td>1. Hi-Desert Medical Center was Designated as a Level 4 Trauma Center.</td>
<td>Loreen Gutierrez</td>
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<tr>
<td>2. STEMI Program</td>
<td>2. STEMI, and Stroke dates are approved and will be hybrid with three based in San Bernardino and one regional meeting.</td>
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<tr>
<td>3. Stroke Program</td>
<td>3. Continuation of Care education is complete.</td>
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<tr>
<td>B. HEMS Utilization Task Force</td>
<td>Utilizing HEMS resources for snake bites in the high desert has become a trend. Cases will be looked at during closed session at a later MAC meeting.</td>
<td>Stephen Patterson</td>
</tr>
<tr>
<td>C. Prehospital Ultrasound Trial Study Update</td>
<td>70 scans were submitted, and the majority were good quality and interpreted correctly. Looking to extend the trial to reach 500 scans.</td>
<td>Dr. Padilla/Michael Neeki</td>
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<td><strong>D. New Member Endorsements</strong></td>
<td>Introduced Sharon Brown, CNO for St. Mary Hospital as the new Specialty Care representative. Private Ambulance companies were consulted, and Craig Bell was brought forward to hold the position of Private Ambulance representative.</td>
<td>Loreen Gutierrez</td>
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<td></td>
<td>Motion to approve Craig Bell as a new member. MSC: Amanda Ward/ Kenneth Fox APPROVED AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
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<td><strong>E. Inyo/Mono County Updates</strong></td>
<td>Inyo/Mono continues to experience a lack of ground resources and an increase in pediatric RSV cases. There has been some difficulty in getting pediatrics transferred out to pediatric centers.</td>
<td>Lisa Davis/ Jessica Wagner</td>
</tr>
<tr>
<td><strong>F. 14100 - Pain Management-Base Hospital Requirement-Route Changes</strong></td>
<td>Motion to approve protocol as written to remove base order requirement for changing routes for fentanyl. MSC: Susie/ Michael Neeki APPROVED AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
<td>Susie Moss</td>
</tr>
<tr>
<td><strong>G. MAC dates for 2023</strong></td>
<td>Motion to approve MAC dates presented. MSC: Seth Dukes/Susie Moss AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
<td>Michelle Hatfield</td>
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<tr>
<td><strong>H. Protocol Review 8050 - Requests for Hospital Diversion and Ambulance Redirection</strong></td>
<td>Policy 8050 was discussed and moved to the next MAC meeting for further comment. MSC: Troy Pennington/Michael Neeki</td>
<td>Michelle Hatfield</td>
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<td>8100 - Ambulance Patient Offload Delay (APOD) 11010 - Medication-Standard Orders</td>
<td>APPROVED</td>
<td>AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
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<td></td>
<td>Policy 8100 was approved as written. MSC: Michael Neeki/Phong Nguyen APPROVED AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
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<td>Changes to Policy 11010 was approved to include age limits on IV Tylenol for pediatrics, 2-14 years old. MSC: Amanda Ward/Kenneth Fox APPROVED AYES: Phong Nguyen, Debbie Bervel, Seth Dukes, Michael Neeki, Kenneth Fox, Troy Pennington, Lisa Davis, Leslie Parham, Steven Patterson, Susie Moss, Amanda Ward, Jessica Wagner, Sharon Brown</td>
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<tr>
<td>IV. Public Comment Period</td>
<td>Request to add verbiage in public comment section on agenda to state public comment is made in person at MAC.</td>
<td>All</td>
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<tr>
<td>V. Future Agenda Items</td>
<td>8050 - Request for Hospital Diversion and Ambulance Redirection Pediatric Cardiac Dysrhythmia - New Policy - Seth Dukes New Chair election</td>
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<tr>
<td>VI. Next Meeting Date</td>
<td>February 23, 2023</td>
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<tr>
<td>VII. Adjournment</td>
<td>Meeting was adjourned at 1515</td>
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<tr>
<td>VIII. Closed Session</td>
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<td></td>
<td>A. Case Reviews</td>
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<td>B. Loop Closure Cases</td>
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## Attendees:

<table>
<thead>
<tr>
<th>NAME</th>
<th>MAC POSITION</th>
<th>EMS AGENCY STAFF</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>P. Brian Savino - LLUMC</td>
<td>Trauma Hospital Physicians (2)</td>
<td>Reza Vaezazizi, MD</td>
<td>Medical Director</td>
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<tr>
<td>Brandon Woodward - ARMC</td>
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<tr>
<td>Melanie Randall - LLUMC</td>
<td>Pediatric Critical Care Physician</td>
<td>Demis Cano</td>
<td>EMS Specialist</td>
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<tr>
<td>Phong Nguyen - RDCH</td>
<td>Non-Trauma Base Physicians (2)</td>
<td>Loreen Gutierrez</td>
<td>Specialty Care Coordinator</td>
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<td>VACANT</td>
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<tr>
<td>Michael Neeki - Rialto FD</td>
<td>Public Transport Medical Director</td>
<td>Jeff Copeland</td>
<td>Sr. EMS Specialist</td>
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<tr>
<td>Seth Dukes - AMR</td>
<td>Private Transport Medical Director</td>
<td>Michelle Hatfield</td>
<td>EMS Specialist</td>
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<tr>
<td>Kevin Parkes - Ontario FD</td>
<td>Fire Department Medical Director</td>
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<tr>
<td>Joy Peters - ARMC</td>
<td>EMS Nurses Representative</td>
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<tr>
<td>Leslie Parham - Chino Valley FD</td>
<td>EMS Officers Representative</td>
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<tr>
<td>Kevin Dearden - Rialto FD</td>
<td>Public Transport Medical Representative (Paramedic/RN)</td>
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<tr>
<td>Susie Moss - AMR</td>
<td>Private Transport Medical Representative (Paramedic/RN)</td>
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<tr>
<td>Lance Brown - LLUMC</td>
<td>Specialty Center Medical Director</td>
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<tr>
<td>Sharon Brown - SMMC</td>
<td>Specialty Center Coordinator</td>
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<tr>
<td>Troy Pennington - Mercy Air</td>
<td>Private Air Transport Medical Director</td>
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<tr>
<td>Stephen Patterson - Sheriff’s Air Rescue</td>
<td>Public Air Transport Medical Director</td>
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<tr>
<td>Debbie Bervel</td>
<td>PSAP Medical Director</td>
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<tr>
<td>Lisa Davis - Sierra Lifeflight</td>
<td>Inyo County Representative</td>
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<td>Jessica Wagner</td>
<td>Mono County Representative</td>
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<tr>
<td>VACANT</td>
<td>Trauma Program Manager Representative</td>
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<tr>
<td>Amanda Ward - Crafton Hills</td>
<td>EMT-P Training Program Representative</td>
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<tr>
<td>Kenneth Fox</td>
<td>Public Safety Field Paramedic</td>
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<tr>
<td>Craig Bell</td>
<td>Private Transport Field Paramedic</td>
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<tr>
<td>VACANT</td>
<td>ICEMA Medical Director Appointee</td>
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REQUESTS FOR AMBULANCE REDIRECTION AND HOSPITAL DIVERSION

I. PURPOSE

To define policy and procedures for hospitals to request temporary redirection of advanced life support (ALS) ambulances.

II. POLICY

- Ambulance redirection based on hospital capacity, census or staffing is not permitted in the ICEMA region and will only be permitted as outlined in this policy.
- This policy applies to the 9-1-1 emergency system as a temporary measure and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.
- If a hospital meets internal disaster criteria, Trauma Center Diversion or any other specialty care centers with unique circumstances, immediate telephone notification must be made to the ICEMA Duty Officer by an administrative staff member who has the authority to determine that criteria has been met for redirection or diversion.
- Hospitals must notify EMS dispatch centers immediately via ReddiNet or available communication modalities.
- Hospitals must maintain a hospital redirection policy that conforms with this policy. The hospital policy shall include plans to educate all appropriate staff on proper utilization of redirection.
- Receiving hospitals cannot redirect an incoming ambulance and diversion/redirection is only permitted as outlined in this policy.
- Within 72 hours of an incident, the hospital must provide ICEMA with a written after action report indicating the reasons for internal disaster, plans activated, adverse patient consequences and the corrective actions taken. The report must be signed by the CEO or designated responsible individual.
- ICEMA may perform unannounced site visits to hospitals on temporary redirection status to ensure compliance with the request for ambulance redirection.
- ICEMA may randomly audit base hospital records to ensure redirected ambulance patients are transported to the appropriate destination.
- ICEMA staff may contact the hospital to determine the reasons for ambulance redirection, under this policy.
- ICEMA may remove any hospital from redirection status using ReddiNet if it is determined that the request is not consistent with this policy.

III. PROCEDURE

A request for redirection of ALS ambulances may be made for the following approved categories:
- CT Redirection (for Non-Specialty Care Centers).
- When Non-Specialty Care Centers experience CT scanner failure, the hospital can go on ambulance redirection using the ReddiNet system for EMS patients who may require CT imaging.

- **Trauma Center Diversion (for use by designated Trauma Centers only)**
  - The on duty trauma surgeon must be involved in the decisions regarding any request for trauma diversion.
  - The trauma team and trauma surgeon (both first and second call) and are fully committed to the care of trauma patients in the operating room and are NOT immediately available for any additional incoming patients meeting approved trauma triage criteria.
  - All operating rooms are occupied with critically injured patients that meet trauma triage criteria.
  - All CT Scanners are inoperable due to scanner failure at a designated Trauma Center.
  - Internal disaster.

  **NOTE**: Diversion is canceled when all designated Trauma Centers are on Trauma Center Diversion.

- **Internal Disaster Diversion**
  - Requests for Internal Disaster Diversion shall apply only to physical plant breakdown affecting the Emergency Department or significant patient services.

  **NOTE**: Examples of Internal Disaster Diversion include bomb threats, explosions, power outage and a nonfunctional generator, fire, earthquake damage, hazardous materials exposure, incidents involving the safety and/or security of a facility.

  - Internal Disaster Diversion shall not be used for hospital capacity or staffing issues.
  - Internal Disaster Diversion will stop all 9-1-1 transports into the facility.
  - The hospital CEO or AOD shall be notified and notification documented in ReddiNet.
  - If the hospital is a designated base hospital, the hospital should consider immediate transfer of responsibility for on-line direction to another base hospital. Notification must be made to the EMS provider.
  - The affected hospital shall enter Internal Disaster Diversion status into ReddiNet immediately.
IV. EXCEPTIONS TO CT AND TRAUMA DIVERSION ONLY

- Basic life support (BLS) ambulances shall not be diverted.
- Ambulances on hospital property shall not be diverted.
- With the exception of Internal Disaster Diversion involving significant plant failure, patients exhibiting unmanageable problems (i.e., difficult to manage airway, uncontrolled hemorrhage, cardiopulmonary arrest) in the field, shall be transported to the closest emergency department.
AMBULANCE PATIENT OFFLOAD DELAY (APOD)

I. PURPOSE

To establish a policy for the safe and rapid transfer of patient care responsibilities between Emergency Medical Services (EMS) personnel and emergency department (ED) medical personnel.

II. CONSIDERATIONS

Delays in the transfer of patient care and offloading of patients delivered to designated receiving hospitals by EMS ambulance adversely affects patient care, safety, and the availability of ambulances for emergency responses throughout Riverside and San Bernardino counties. It is incumbent upon receiving hospitals and ambulance providers to minimize the time required to transfer patient care and return ambulances to service to ensure optimal patient care, safety, and EMS system integrity.

III. DIRECTION OF EMS FIELD PERSONNEL

EMS field personnel have a responsibility to must continue to provide and document patient care in accordance with ICEMA treatment policies and protocols prior to the transfer of patient care to the designated receiving hospital, ED medical personnel. Medical control and management of the EMS system, including EMS field personnel, remain the responsibility of the EMS agency medical director and all care provided to the patient must be pursuant to the Inland Counties Emergency Medical Agency (ICEMA) treatment protocols and policies.

IV. PATIENT CARE RESPONSIBILITY

The ultimate responsibility for patient care belongs to the designated receiving hospital once the patient arrives on hospital grounds. Designated receiving hospitals should implement processes for ED medical personnel to immediately triage and provide the appropriate emergency medical care for ill or injured patients upon arrival at the ED by ambulance.

V. TRANSFER OF PATIENT CARE

Patients Under Care of EMS Field Personnel

Upon arrival of a patient at the hospital by ambulance the ED medical personnel should make every attempt to receive a verbal patient report and offload the patient to a hospital bed or other suitable sitting or reclining device at the earliest possible time not to exceed 25 minutes. During the transfer of care to ED medical personnel, EMS field personnel will provide a verbal patient report containing any pertinent information necessary for the ongoing care of the patient. Transfer of patient care is completed once the ED medical staff has received a verbal patient report. If the transfer of care and patient offloading from the ambulance gurney exceeds the 25 minute standard, it will be documented and tracked as APOD.

The transporting EMS field personnel are not responsible to continue monitoring the patient or provide care within the hospital setting after transfer of patient care to ED medical personnel has occurred.

EMS field personnel are responsible for immediately returning to response ready status once patient care has been transferred to ED medical personnel and the patient has been offloaded from the ambulance gurney.
VI. APOD MITIGATION PROCEDURES

Designated receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS field personnel to the ED medical personnel within 25 minutes of arrival at the ED.

ED medical personnel should consider the following to prevent APOD:

- Immediately acknowledge the arrival of each patient transported by EMS;
- Receive a verbal patient report from EMS field personnel; and
- Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 25 minutes of arrival at the hospital ED.

If APOD does occur, the hospital should make every attempt to:

- Provide a safe area in the ED within direct sight of ED medical personnel where EMS personnel ambulance crew can temporarily wait while the hospital’s patient remains on the ambulance gurney.
- Inform the attending paramedic or EMT of the anticipated time for the offload of the patient.
- Provide information to the supervisor of the EMS field personnel regarding the steps that are being taken by the hospital to resolve APOD.

Hospitals will provide written details to ICEMA and EMS providers of policies and procedures that have been implemented to mitigate APOD including: and assure effective communication with affected partners:

- Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD, including but not limited to:
  - ED/Attending Physician
  - ED Nurse Manager/Director or Designee (i.e., Charge Nurse)
  - House Supervisor
  - Administrator on call

- Processes to alert the following affected partners via ReddiNet when a condition exists that affects the timely offload of ambulance patients:
  - Local receiving hospitals/base hospitals
  - Fire department and ambulance dispatch centers

- Processes for ED medical personnel to immediately respond to and provide care for the patient if the attending EMS field providers personnel to alert the ED medical personnel of a decline in the patient’s condition of a patient being temporarily held on the ambulance gurney.
EMS field personnel are directed to do the following to prevent APOD:

- Provide the receiving hospital ED with the earliest possible notification via two-way radio that a patient is being transported to their facility.
- Utilizing the appropriate safety precautions, walk-in ambulatory patients or use a wheelchair rather than an ambulance gurney if appropriate for the patient’s condition.
- Provide a verbal patient report to the ED medical personnel within 25 minutes of arrival to the ED.
- Contact the EMS supervisor for direction if the ED medical personnel do not offload the patient within the 25 minute ambulance patient offload time standard.
- Complete the ICEMA required authorized patient care documentation.
- Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established in this policy.

**VII. CONTENT AND FORMATTING OF THE VERBAL PATIENT REPORT**

The verbal patient report may be provided by face-to-face communication utilizing the SBAR format. The verbal patient report will include the following elements:

**Situation**

- Patient age, sex, weight
- Patient condition (mild, moderate or severe)
- Patient chief complaint

**Background**

- Mechanism of injury or history of present illness
- Assessment findings
  - Responsiveness/Glasgow Coma Scale (GCS)
  - Airway
  - Breathing
  - Circulation
  - Disability
- Vital Signs
- Past medical history, medications and allergies

**Assessment**

- Primary impression

**Recommendations**

- Treatment/interventions provided
- Patient response to treatment/interventions
- Request for orders (If it is a medical direction call)
VIII. CLINICAL PRACTICES FOR EMS FIELD PERSONNEL TO REDUCE APOD

The EMS field personnel shall utilize sound clinical judgment and follow the appropriate ICEMA policies and treatment protocols including:

- Initiate care as clinically indicated with the appropriate basic life support (BLS) and advanced life support (ALS) interventions.

- Initiate vascular access only as clinically indicated. IV therapy should only be initiated pursuant to ICEMA treatment protocols for patients that require the following:
  - Administration of IV medication(s), or
  - Administration of IV fluid bolus or fluid resuscitation.

- In the judgement of the attending paramedic the patient’s condition could worsen and either (a) or (b) noted above may become necessary prior to arrival at the receiving hospital ED.

- Discontinue ECG monitoring before removing the patient from the ambulance if there are no clinical indications for cardiac monitoring.

VIIIIX. APOD UNUSUAL EVENTS

In response to a major emergency that requires immediate availability of ambulances the San Bernardino County Medical Health Operational Area Coordinator may give direction to EMS field providers to immediately transfer patient care to the ED medical personnel and return to service to support the EMS system resource needs.

The proliferation of APOD that leads to the lack of sufficient ambulances to respond to emergencies are considered APOD Unusual Events. These events threaten public health and safety by preventing EMS response to emergency medical incidents. To mitigate the effects of these APOD Unusual Events the following are hereby established:

- Criteria for an APOD Unusual Event If offload delay exceeds 25 minutes, EMS field personnel will transfer care of the patient to ED medical personnel and transition patient to a gurney cot bed chair wheelchair or waiting room that is appropriate for patient’s condition.

- Transfer of care will include BLS and ALS patients that are determined to be stable and safe to transfer, based on EMS field personnel evaluation.

- EMS field personnel are required to give a verbal patient report containing any pertinent information necessary for the ongoing care of the patient.

- EMS field personnel will complete and post the written ePCR in accordance with existing policy.

- APOD exceeding 25 minutes is occurring, and;

- The ambulance provider identifies and documents low EMS system ambulance availability due to APOD.

APPO Unusual Event Procedures
EMS field personnel are authorized to inform ED medical personnel that they are transitioning patient care and immediately offloading a patient on APOD to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition provided the patient meets the following criteria:

- Stable vital signs
- Alert and oriented
- No ALS interventions in place
- Is not on a Welfare and Institutions Code (WIC) 5150 hold

EMS field personnel shall make every attempt to notify ED medical personnel that they must immediately return to service.

EMS field personnel may use the written EMS report for transfer of care if ED medical personnel are unavailable to take a verbal report and then post ePCR to hospital dashboard.

In the event of a major emergency that requires immediate availability of ambulances, the San Bernardino County Medical Health Operational Area Coordinator may give direction to EMS field personnel to immediately transfer patient care to ED medical personnel and return to service to support the EMS system resource needs.
AMBLANCE PATIENT OFFLOAD DELAY (APOD)

I. PURPOSE

To establish a policy for the safe and rapid transfer of patient care responsibilities between Emergency Medical Services (EMS) personnel and emergency department (ED) medical personnel.

II. CONSIDERATIONS

Delays in the transfer of patient care and offloading of patients adversely affect patient care.

III. DIRECTION OF EMS FIELD PERSONNEL

EMS field personnel must continue to provide and document patient care in accordance with ICEMA treatment policies and protocols prior to the transfer of patient care to the designated receiving hospital.

IV. PATIENT CARE RESPONSIBILITY

The responsibility for patient care belongs to the designated receiving hospital once the patient arrives on hospital grounds.

V. TRANSFER OF PATIENT CARE

Patients Under Care of EMS Field Personnel

Transfer of patient care is completed once the ED medical staff has received a verbal patient report. If the transfer of care and patient offloading from the ambulance gurney exceeds 25 minutes, it will be documented and tracked as APOD.

EMS field personnel are responsible for immediately returning to response ready status once patient care has been transferred to ED medical personnel and the patient has been offloaded from the ambulance gurney.

VI. APOD MITIGATION PROCEDURES

ED medical personnel should consider the following to prevent APOD:

- Immediately acknowledge the arrival of each patient transported by EMS;
- Receive a verbal patient report from EMS field personnel; and
- Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 25 minutes of arrival at the hospital ED.

If APOD does occur, the hospital should make every attempt to:

- Provide a safe area in the ED for the EMS personnel to temporarily wait while the hospital’s patient remains on the ambulance gurney.
- Inform the attending paramedic or EMT of the anticipated time for the offload of the patient.
• Provide information to the supervisor of the EMS field personnel regarding the steps that are being taken by the hospital to resolve APOD.

Hospitals will provide written details to ICEMA and EMS providers of policies and procedures that have been implemented to mitigate APOD including:

• Processes for internal escalation of APOD:
  ➢ ED/Attending Physician
  ➢ ED Nurse Manager/Directory or Designee (i.e., Charge Nurse)
  ➢ House Supervisor
  ➢ Administrator on call

• Processes to alert via ReddiNet
  ➢ Local receiving hospitals/base hospitals
  ➢ Fire department and ambulance dispatch centers

• Processes for EMS field providers to alert the ED medical personnel of a decline in the patient's condition.

• EMS field personnel are directed to do the following to prevent APOD:
  • Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established in this policy.

VII. CLINICAL PRACTICES FOR EMS FIELD PERSONNEL TO REDUCE APOD

The EMS field personnel shall utilize sound clinical judgment and follow the appropriate ICEMA policies and treatment protocols including:

• Initiate care as clinically indicated with the appropriate basic life support (BLS) and advanced life support (ALS) interventions.

• Initiate vascular access only as clinically indicated.

• Discontinue ECG monitoring before removing the patient from the ambulance if there are no clinical indications for cardiac monitoring.

VIII. APOD UNUSUAL EVENTS

In response to a major emergency that requires immediate availability of ambulances the San Bernardino County Medical Health Operational Area Coordinator may give direction to EMS field providers to immediately transfer patient care to the ED medical personnel and return to service to support the EMS system resource needs.

• If offload delay exceeds 25 minutes, EMS field personnel will transfer care of the patient to ED medical personnel and transition patient to a gurney cot bed chair wheelchair or waiting room that is appropriate for patient's condition.

• Transfer of care will include BLS and ALS patients that are determined to be stable and safe to transfer, based on EMS field personnel evaluation.
- EMS field personnel are required to give a verbal patient report containing any pertinent information necessary for the ongoing care of the patient.
- EMS field personnel will complete and post the written ePCR in accordance with existing policy.