



# Inland Counties Emergency Medical Agency

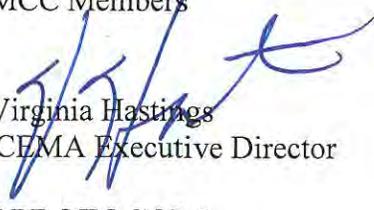
*Serving San Bernardino, Inyo, and Mono Counties*

*Virginia Hastings, Executive Director*

*Reza Vaezazizi, M.D., Medical Director*

**DATE:** June 16, 2011

**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.  ICEMA Medical Director  
Virginia Hastings  ICEMA Executive Director

**SUBJECT: PUBLIC COMMENT PERIOD - AEMT PROTOCOLS**

Over the past several years, in conjunction with San Bernardino County Sheriff's Search and Rescue team, West Valley Division, ICEMA participated in a trial study for EMTs to provide specific limited ALS (LALS) services to patients in remote wilderness areas. Through this study and Statewide input of existing EMT-II programs, the State EMS Authority implemented the Advanced EMT (AEMT) scope of practice.

Title 22 of the California Code of Regulations, Chapter 3 authorizes local EMS agencies to establish LALS programs, through program approval and written agreements. ICEMA has established the LALS program and application processes to allow providers to upgrade from BLS provider status to LALS service to enable higher levels of care to citizens, particularly in rural and wilderness areas. Interested agencies will be required to submit a specialty program application, enter into a written agreement and be approved by ICEMA. Additional training and certification of personnel will also be required for program approval.

Attached are the LALS Advanced EMT protocols available for public comment. The protocols were adapted from existing protocols to include the AEMT scope of practice and will be used exclusively by ICEMA approved LALS providers. ICEMA encourages all system participants to submit comments/recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until July 15, 2011 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to [SShimshy@cao.sbcounty.gov](mailto:SShimshy@cao.sbcounty.gov). A recommendation was made and approved by the Medical Advisory Committee to release these protocols for a shortened comment period in order to be presented at the July 2011 Emergency Medical Care Committee (EMCC) meetings held in all three counties.

RV/VH/DWS/SS/mae

Attachments: A-EMT Limited ALS Protocols



## LIMITED 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, Limited ALS, (transport and non-transport) and BLS transport vehicles shall be inspected annually.

### MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	L-ALS Non-Transport
Activated Charcoal 25 gm	2
Adrenaline (Epinephrine) 1:1000 1 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg	4
Aspirin, chewable – 81mg tablet	2
Dextrose 50% 25 gm preload	2
Glucagon 1 mg	1
Glucose paste	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Irrigating Saline and/or Sterile Water (1000cc)	1
Naloxone (Narcan) 2 mg preload (needle less)	2
Nitroglycerine – Spray or tabs 0.4mg metered dose	2
Normal Saline for Injection (10cc)	2
Normal Saline 500cc	2
Normal Saline 1000cc	1

### AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	L-ALS Non-Transport
Adult non-rebreather mask	2
Infant Simple Mask	1
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	1 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	1 each
Nasal cannulas – pediatric and adult	2 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each

<b>Exchanged Airway/Suction Equipment</b>	<b>L-ALS Non-Transport</b>
Oropharyngeal Airways – (infant, child, and adult)	1 each
Pediatric non-rebreather O2 mask	2
Small volume nebulizer with universal cuff adaptor	2
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent)	1 each
Adult	1 each
Water soluble lubricating jelly	1

<b>Non-Exchange Airway/Suction Equipment</b>	<b>L-ALS Non-Transport</b>
Flashlight/penlight	1
Portable Oxygen with regulator – 10L/min for 20 minutes	1
Manual powered suction device	1
Pulse Oximetry device	1
Stethoscope	1

**IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT**

<b>IV/Needles/Syringes/Monitoring Equipment</b>	<b>L-ALS Non-Transport</b>
Disposable Tourniquets	2
Glucose monitoring device with compatible strips and OSHA approved single use lancets	1
IV Catheters – sizes 14, 16, 18, 20, 22, 24	2 each
Microdrip Administration Set (60 drops/cc)	1
Macro drip Administration Set (10 drops/cc)	3
Mucosal Atomizer Device (MAD) for nasal administration of medication	2
Pressure Infusion Bag (disposable)	1
Razors	1
Safety Needles – 20 or 21gauge and 23 or 25 gauge	2 each
Saline Lock Large Bore Tubing Needle less	2
Sterile IV dressing	2
Syringes w/wo safety needles – 1cc, 3cc, 10cc catheter tip	2 each

<b>Non-Exchange IV/Needles/Syringes/Monitoring Equipment</b>	<b>L-ALS Non-Transport</b>
AED/defib pads	2
Blood pressure cuff – large adult or thigh cuff, adult, child and infant	1
Needle disposal system (OSHA Approved)	1
Thermometer - Mercury Free with covers	1





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## GENERAL PATIENT CARE GUIDELINES

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### PURPOSE

To provide guidelines for providing the minimum standard of care for all patient contacts.

### AUTHORITY

Title 22, Division 9, Chapter 4, Sections 1001, 100146 and 100147 of the California Health and Safety Code.

### DEFINITIONS

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

1. Altered level of consciousness.
2. Sign and/or symptoms of skeletal or soft tissue injuries.
3. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
4. Evidence that the individual was subject to significant force.

**Patient Contact:** Determined to be achieved when any on duty BLS or ALS field provider comes into the presence of a patient as defined above.

### BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
  - a. Airway, breathing and circulatory status.
  - b. Subjective assessment of the patients' physical condition and environment.
  - c. Objective assessment of the patients' physical condition and environment.
  - d. Vital signs.

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

#### **LIMITED ALS INTERVENTIONS**

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

3. Augment BLS treatment with advanced treatments as indicated or available.
4. Initiate airway control as needed with the appropriate LALS adjunct.
5. Initiate vascular access as clinically indicated.



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## PHYSICIAN ON SCENE

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### **PURPOSE**

To establish criteria for an A-EMT 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 A-EMT 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 accompanies 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.

## **RESPONSIBILITIES**

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

1. Notify Base Station that a physician is taking charge of the patient(s).
2. Maintain control of drugs and equipment from the Limited ALS unit. Inform the physician of drugs and equipment available.
3. Offer assistance to the physician on scene. The A-EMT 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.



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## RESPONSIBILITY FOR PATIENT MANAGEMENT POLICY

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### PURPOSE

To define the responsibility for patient care management in the prehospital setting. Within the ICEMA region, in the event both public and private emergency medical care personnel arrive on the scene with the same qualifications, patient care management responsibility will rest with the first to arrive.

### AUTHORITY

Health & Safety Code, Division 2.5, Chapter 5, Section 1798.6 (a & c).

- a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic, A-EMT or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care.
- b) If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.
- (c) Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in determination of relevant risks.

### PROCEDURE

1. An A-EMT may transfer patient management responsibility to an EMT for transportation, **without Base Station direction**, only under the following conditions:
  - a. When the patient does not meet criteria for Base Station contact and has not received Limited ALS care.
  - b. When operating under the MCI Protocol, Reference #5050.

- c. When operating under the Local Medical Emergency Protocol, Reference #9060 AEMT.
2. The Base Station should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.
3. In the event of radio communication failure, a Limited ALS unit may not transfer patient management responsibility to an EMT for transportation.



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## **REPORTING INCIDENTS OF SUSPECTED ABUSE POLICY**

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### **PURPOSE**

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 8am - 5pm **or** 911 after hours

**Mono County:** 1-800-340-5411 M-F 8am - 5pm **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 8am - 5pm **or** 911 after hours

**Mono County:** 1-800-340-5411 M-F 8am - 5pm **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 CRISIS line number:**

1-800-231-4024

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



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## ORGAN DONOR INFORMATION

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### 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.



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## **LOCAL MEDICAL EMERGENCY POLICY**

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### **PURPOSE**

To provide guidelines to prehospital care providers and personnel regarding the treatment and transportation of patients during a declared Local Medical Emergency.

### **POLICY**

Prehospital care providers and personnel shall follow the procedures and guidelines outlined below regarding the treatment and transportation of patients during a declared Local Medical Emergency.

### **DEFINITION**

**Local Medical Emergency:** For the purposes of this policy, a Local Medical Emergency shall exist when a “local emergency”, as that term is used in government Code Section 8630, has been proclaimed by the governing body of a city or the county, or by an official so designated by ordinance.

### **ENACTMENT OF PROTOCOL**

The following procedures shall apply during a Local Medical Emergency:

1. A public safety agency of the affected jurisdiction shall notify the County Communications Center of the proclamation of a local emergency, and shall provide information specifying the geographical area that the proclamation affects.
2. The Communications Center shall notify:
  - a. The County Health Officer/Designee.
  - b. ICEMA.
  - c. The County Sheriff’s Department.
  - d. Area prehospital provider agencies.
  - e. Area hospitals.

3. This protocol shall remain in effect for the duration of the declared Local Medical Emergency or until rescinded by the County Health Officer (Operational Area Medical Coordinator) or his/her designee.

### **MEDICAL CONTROL**

1. ALS, Limited ALS, and BLS personnel may function within their Scope of Practice as established in the standard Practice Protocols without Base Station contact.
2. No care will be given unless the scene is secured and safe for EMS personnel.
3. An MCI will be initiated by either Comm Center or ICEMA. Patient destination will be determined as part of the MCI.
4. Transporting agencies may utilize BLS units for patient transport as dictated by transport resource availability. In cases where no ambulance units are available, personnel will utilize the most appropriate method of transportation at their disposal.
5. Patients too unstable to be transported outside the affected area should be transferred to the closest secured appropriate facility.
6. County Communications Center should be contacted on the MED NET frequency for patient destination by the transporting unit.
7. Base Station contact criteria outlined in protocol #5040, Radio Communication, may be suspended by the ICEMA Medical Director. EMS provider agencies will be notified. Receiving facilities should be contacted with following information once enroute:
  - a. ETA.
  - b. Number of patients.
  - c. Patient status: Immediate, delayed or minor.
  - d. Brief description of injury.
  - e. Treatment initiated.

### **DOCUMENTATION**

First responder and transporting agencies may utilize approved triage tags as the minimum documentation requirement. The following conditions will apply:

1. One corner to be kept by the jurisdictional public safety agency. A patient transport log will also be kept indicating time, incident number, patient number (triage tag), and receiving facility.
2. One corner to be retained by the transporting agency. A patient log will also be maintained indicating time, incident number, patient number (triage tag) and receiving facility.
3. Remaining portion of triage tag to accompany patient to receiving facility which is to be entered into the patient's medical record.
4. All Radio Communication Failure reports may be suspended for duration of the Local Medical Emergency.

All refusals of treatment and/or transport will be documented as scene safety allows.

### **COUNTY COMMUNICATIONS CENTER**

County Communications Center will initiate a MCI according to ICEMA policies. This information will be coordinated with appropriate fire/rescue zone dispatch centers and medical unit leaders in the field as needed.

### **RESPONSIBILITIES OF THE RECEIVING FACILITIES**

1. Receiving facilities upon notification by the County Communications Center of a declared Local Medical Emergency will provide hospital bed availability and Emergency Department capabilities for immediate and delayed patients.
2. Receiving facilities will utilize ReddiNet to provide the County Communications Center and ICEMA with hospital bed capacity status every four (4) hours, upon request, or when capacities are reached.
3. It is strongly recommended that receiving facilities establish a triage area in order to evaluate incoming emergency patients.
4. In the event that incoming patients overload the service delivery capacity of the receiving hospital, it is recommended that the hospital consider implementing their disaster plan.
5. Saturated hospitals may request evacuation of stable in-patients. Movement of these patients should be coordinated by County Communications Center and in accordance with Armed Services Medical Regulation Office (ASMRO) system categories.



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## **APPLYING PATIENT RESTRAINTS GUIDELINES**

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### **PURPOSE**

To provide guidelines on the use of restraints in the field or during transport for patients who are violent or potentially violent, or who may harm themselves or others.

### **AUTHORITY**

California Code of Regulations, Title 22, Sections 1000075 and 10000159. Welfare and Institutions Code 5150. California Administrative Code, Title 13, Sections 1103.2 Health and Safety Code, Section 1798.6.

### **PRINCIPLES**

1. The safety of the patient, community and responding personnel is of paramount concern when following this policy.
2. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others.
3. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders.
4. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.
5. Restraints should be applied by law enforcement whenever possible. If applied, an officer is required to remain available at the scene or during transport to remove or adjust the restraints for patient safety.
6. This policy is not intended to negate the need for law-enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene-management control.

### **PROCEDURE**

The following procedures should guide EMS personnel in the application of restraints and the monitoring of the restrained patient:

1. Restraint equipment must be either padded leather restraints or soft restraints (e.g., posey, Velcro or seat-belt type). Both methods must allow for quick release.
2. EMS personnel shall **not** apply following forms of restraint:
  - a. Hard plastic ties, any restraint device requiring a key to remove, hand cuffs or hobble restraints.
  - b. Backboard, scoop stretcher or flat as a "sandwich" restraint.
  - c. Restraining a patient's hands and feet behind the patient (e.g., hog-tying).
  - d. Methods or other materials applied in a manner that could cause vascular or neurological compromise.
3. Restraint equipment applied by law enforcement (handcuffs, plastic ties or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest, and to take full tidal volume breaths.
4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene-management safety. The officer shall accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.
5. Patients should be transported in a supine position if at all possible. EMS personnel must ensure that the patient's position does not compromise respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
6. Restrained patients shall be transported to the most appropriate receiving facility within the guidelines of Protocol Reference #9030 AEMT, Responsibility for Patient Management. The only allowable exception is a 5150 order presented when direct admission to a psychiatric facility has been arranged.

## DOCUMENTATION

Documentation on the patient care form shall include:

1. The reasons restraints were needed.
2. Which agency applied the restraints (e.g., EMS, law enforcement).

3. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve and motor function every fifteen (15) minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation, and may be difficult to monitor.
4. Respiratory status should be evaluated for rate and quality every fifteen (15) minutes or more often as clinically indicated while restrained.



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## CARE OF MINORS IN THE FIELD

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### PURPOSE

To provide guidelines for EMS personnel for treatment and/or transport of minors in the field.

### AUTHORITY

California Welfare and Institutions Code Section 625, Civil Code, sections 25, 34 and 62

### DEFINITIONS

**Consent:** Except for circumstances specifically prescribed by law, a minor is not legally competent to consent to, or refuse medical care.

**Voluntary consent:** Treatment and/or transport of a minor shall be with the verbal or written consent of the parent or legal representative.

**Involuntary consent:** In the absence of a parent or legal representative, emergency treatment and/or transport may be initiated without consent.

**Minor:** Any person under eighteen (18) years of age.

**Minor not requiring parental consent:** A person who is decreed by the court as an emancipated minor, has a medical emergency and parent is not available, is married or previously married, is on active duty in the military, is pregnant and requires care related to the pregnancy, is twelve (12) years or older and in need of care for rape and/or sexual assault, is twelve (12) years or older and in need of care for a contagious reportable disease or condition, or for substance abuse.

**Legal Representative:** A person who is granted custody or conservatorship of another person.

**Emergency:** An unforeseen condition or situation in which the individual has need for immediate medical attention, or where the potential for immediate medical attention is perceived by EMS personnel or a public safety agency

## **PROCEDURE**

### **Treatment and/or Transport of Minor**

1. For all ill or injured minors under the age of nine (9) years, Base Station contact is required before leaving scene.
2. In the absence of a parent or legal representative, minors with an emergency condition shall be treated and transported to the medical facility most appropriate to the needs of the patient.
3. In the absence of a parent or legal representative, minors with a non-emergency condition require EMS personnel to make reasonable effort to contact a parent or legal representative before initiating treatment and/or transport. If a parent or legal representative cannot be reached and minor is transported, EMS personnel shall make every effort to inform the parent or legal representative of where the minor has been transported, and request that law enforcement accompany the minor patient to the hospital.

### **Minor Not Requiring Immediate Treatment and/or Transport**

1. A minor evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have an illness or injury not requiring immediate treatment and/or transportation, may be released to:
  - a. Parent or legal representative.
  - b. Designated care giver over eighteen (18) years of age.
  - c. Law Enforcement.
2. EMS personnel shall document on the patient care record to whom the minor was released.

### **Minor Attempting to Refuse Indicated Care**

1. Contact Base Station.
2. Attempt to contact parent or legal representative for permission to treat and/or transport.
3. Contact Law Enforcement and request minor to be taken into temporary custody for treatment and/or transport (only necessary in the event parents or legal representative cannot be contacted).



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## PATIENT REFUSAL OF CARE GUIDELINES - ADULT

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### PURPOSE

To provide guidance for EMS Personnel whose advice to an individual for treatment and/or transport is being refused.

### AUTHORITY

Health and Safety Code, Section 1797.220

### PRINCIPLE

Recognizing that the decision to be transported by a provider agency is solely the responsibility of the individual, a process should be in place to document such "refusal of services", to protect both the individual and EMS personnel. An AMA should be initiated whenever the highest medical authority on scene determines that a person would benefit from assessment, treatment and/or transport and that person refuses.

### DEFINITIONS

**AMA:** A term used to designate "against medical advice".

**Consent:** Consent is defined as the agreement and acceptance as to opinion or course of action.

**Emergency:** The American Ambulance Association (AAA) defines an "emergency" as "unforeseen condition of a pathophysiological nature, which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention".

### CONSENT

1. Legal consent procedures should not delay immediately required treatment.
2. An individual has the responsibility to consent to or refuse treatment. If he/she is unable to do so consent is then considered implied.
3. In non-emergency cases, consent should be obtained from the individual.

4. For treatment of minors or a definition of emancipated minors refer to Protocol Reference #9080 AEMT Care of Minors in the Field.

### **MENTAL COMPETENCE**

1. An individual is mentally competent if he or she:
  - a. Is capable of understanding the nature and consequences of the proposed treatment.
  - b. Has sufficient emotional control, judgment and discretion to manage his or her own affairs.
2. An individual having an understanding of what may happen if treated or not treated, and is oriented to person, place, time and purpose.
3. An individual with an altered level of consciousness will be unlikely to fulfill these criteria.
4. If the individual is not deemed mentally competent, the person should be treated and transported. It is preferable under such circumstances to obtain concurrence of a police officer in this course of action.

### **REFUSAL OF CARE DOCUMENTATION**

In accordance with these guidelines, the following should be carefully documented on the patient care record:

1. The individual's chief complaint, mechanism of injury, level of orientation/level of consciousness.
2. Base Station Contact per Protocol Reference #5040, Radio Communication.
3. Any medical treatment or evaluation needed and refused.
4. The need for emergency transportation; also if transport by means other than an ambulance could be hazardous due to the individual's injury or illness.
5. Individual advised that potential harm could result without emergency medical treatment and/or transport.
6. Individual provided with a refusal advice sheet, and if he or she would accept the refusal advice sheet.

7. A copy of the patient care record with the individual's signature of refusal will be kept by the EMS provider agency per Protocol Reference #2010, Requirements for Patient Care Records.



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## KING AIRWAY DEVICE (PERILARYNGEAL) - ADULT

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### FIELD ASSESSMENT/TREATMENT INDICATORS

Use of the King Airway adjunct may be performed only on those patients who meet **ALL** of the following criteria:

1. Unresponsive and apneic (less than 6 breaths per minute).
2. No gag reflex.
3. Anyone over four (4) feet in height
  - a. 4-5 feet: Size 3 (connector color: yellow)
  - b. 5-6 feet: Size 4 (connector color: red)
  - c. 6 feet and over: Size 5 (connector color: purple)

### ADDITIONAL CONSIDERATIONS

1. BVM management not adequate or effective.
2. A King Airway adjunct should not be removed unless there is a malfunction.
3. Medications may **NOT** be given via the King Airway.

### CONTRAINDICATIONS

1. Conscious patients with an intact gag reflex.
2. Known ingestion of caustic substances.
3. Suspected foreign body airway obstruction (FBAO).
4. Facial and/or esophageal trauma.
5. Patients with known esophageal disease (cancer, varices, surgery, etc.).

## PROCEDURE

1. Using the information provided, choose the correct KING LTS-D size based on patient height.
2. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 3 – 60 ml; size 4 – 80 ml; size 5 – 90 ml). Prior to insertion, disconnect Valve Actuator from Inflation Valve and remove all air from both cuffs.
3. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube taking care to avoid introduction of lubricant in or near the ventilatory openings.
4. Have a spare KING LTS-D ready and prepared for immediate use.
5. Pre-oxygenate.
6. Position the head. (The ideal head position for insertion of the KING LTS-D is the “sniffing position”.)
7. Hold the KING LTS-D at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.
8. With the KING LTS-D rotated laterally 45-90°, introduce tip into mouth and advance behind base of tongue.
9. Rotate the tube back to the midline as the tip reaches the posterior wall of the pharynx.
10. Without exerting excessive force, advance KING LTS-D until base of connector is aligned with teeth or gums.
11. Holding the KLT 900 Cuff Pressure Gauge in non-dominant hand, inflate cuffs of the KING LTS-D to 60 cm H<sub>2</sub>O. If a cuff pressure gauge is not available and a syringe is being used to inflate the KING LTS-D, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (just seal volume).
12. Attach the breathing circuit to the 15 mm connector of the KING LTS-D. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

13. Reference marks are provided at the proximal end of the KING LTS-D which when aligned with the upper teeth give an indication of the depth of insertion.
14. Confirm proper position by auscultation and chest movement.
15. Readjust cuff inflation to 60 cm H<sub>2</sub>O (or to just seal volume).
16. Secure KING LTS-D to patient.

### **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 twenty-four (24) hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.



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## KING AIRWAY DEVICE (PERILARYNGEAL) – PEDIATRIC (Less than 15 years of age)

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### FIELD ASSESSMENT/TREATMENT INDICATORS

Use of the King Airway adjunct may be performed only on those patients who meet **ALL** of the following criteria:

1. Unresponsive and apneic (less than 6 per minute).
2. No gag reflex.
3. Pediatric patients meeting the following criteria:
  - a. 35-45 inches or 12-25 kg: Size 2 (connector color: green)
  - b. 41-51 inches or 25-35 kg: Size 2.5 (connector color: orange).

### ADDITIONAL CONSIDERATIONS

1. BVM management not adequate or effective.
2. A King Airway adjunct should not be removed unless there is a malfunction.
3. Medications may **NOT** be given via the King Airway.

### CONTRAINDICATIONS

1. Conscious patients with an intact gag reflex.
2. Known ingestion of caustic substances.
3. Suspected foreign body airway obstruction (FBAO).
4. Facial and/or esophageal trauma.
5. Patients with known esophageal disease (cancer, varices, surgery, etc.).

**PROCEDURE**

1. Using the information provided, choose the correct KING LT size based on patient height.
2. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 2: 25–35 ml; size 2.5: 30-40 ml). Prior to insertion, disconnect Valve Actuator from Inflation Valve and remove all air from both cuffs.
3. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube taking care to avoid introduction of lubricant in or near the ventilatory openings.
4. Have a spare KING LT ready and prepared for immediate use.
5. Pre-oxygenate.
6. Position the head. (The ideal head position for insertion of the KING LT is the “sniffing position.”)
7. Hold the KING LT at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.
8. With the KING LT rotated laterally 45-90°, introduce tip into mouth and advance behind base of tongue.
9. Rotate the tube back to the midline as the tip reaches the posterior wall of the pharynx.
10. Without exerting excessive force, advance KING LT until base of connector is aligned with teeth or gums.
11. Holding the KLT 900 Cuff Pressure Gauge in non-dominant hand, inflate cuffs of the KING LT to 60 cm H<sub>2</sub>O. If a cuff pressure gauge is not available and a syringe is being used to inflate the KING LT, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (just seal volume).
12. Attach the breathing circuit to the 15 mm connector of the KING LT. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

13. Reference marks are provided at the proximal end of the KING LT which when aligned with the upper teeth give an indication of the depth of insertion.
14. Confirm proper position by auscultation and chest movement.
15. Readjust cuff inflation to 60 cm H<sub>2</sub>O (or to just seal volume).
16. Secure KING LT to patient.

### **DOCUMENTATION**

In the event the receiving physician discovers the device is improperly placed, attached is an Incident Report that must be filled out and forwarded to ICEMA within one (1) week by the receiving hospital.



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## AUTOMATIC EXTERNAL DEFIBRILLATION (AED) - BLS

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### PURPOSE

To identify guidelines for the use of the AED for all patients one (1) year of age or older in cardiac arrest. The overall goal of the AED program is to provide for rapid defibrillation and transfer of patients to an ALS provider as quickly as possible.

### FIELD ASSESSMENT/TREATMENT INDICATORS

All of the following criteria must be met prior to applying the AED machine:

1. Unresponsive, pulseless and apneic ( "gaspings" breaths).
2. One (1) year of age or older.
3. Have an apparent body temperature greater than 86 degrees F.

If patient meets the criteria per Protocol Reference #12010, Determination of Death, or Protocol Reference #12020, Withholding Resuscitation, AED application is not indicated.

### PROCEDURE

1. Initiate immediate CPR.
2. Power on the AED.
3. Place appropriate pads according to manufacturer's guidelines. If the AED is equipped with a pediatric attenuator, it should be utilized for children between one (1) and nine (9) years of age. CPR is not to be interrupted except briefly for rhythm assessment.
4. Analyze rhythm.
  - a. If shocks are required, each shock should be immediately followed by two (2) minutes of CPR.
  - b. If additional shocks are not required:
    - i. If patient begins to move, maintain appropriate airway and oxygenation; obtain and monitor vital signs throughout care.

- ii. If patient remains unresponsive, pulseless and apneic, continue CPR for two (2) minutes and reanalyze.
5. Continue care as indicated by patient condition until ALS providers assume care or patient starts to move.
6. BLS agencies may only transfer care to a provider of equal or greater level. If a BLS transport agency is not an approved AED service provider, the AED personnel must accompany the patient with the appropriate equipment.

### **DOCUMENTATION AND QUALITY IMPROVEMENT**

1. BLS agencies shall complete an ICEMA approved patient care report form and data collection device per Protocol Reference #2010, Requirements for Patient Care Records.
2. PS-D agencies must provide documentation on ICEMA approved form.
3. Use of the AED shall be evaluated by the provider agency through their QI Plan. All data will be used to compile their annual report to ICEMA.

### **SPECIAL NOTE**

AED units should be programmed to the latest 2010 AHA Guidelines for CPR and Emergency Cardiac Care standards for defibrillation for adults and pediatrics no later than December 31, 2011. Until personnel and equipment have been updated to the new guidelines, agencies should continue to perform CPR as trained and follow the AED prompts as directed.



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## **AXIAL SPINAL STABILIZATION**

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### **FIELD ASSESSMENT/TREATMENT INDICATORS**

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

1. Patient meets Mechanism of injury.
2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles.
3. Unconscious patients where the mechanism of injury is unknown.
4. All intubated neonatal and pediatric patients.
5. Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.
6. Altered mental status.
7. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).
8. Additional sites of significant distracting pain or is experiencing emotional distress.
9. Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.
10. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.
11. Any other condition that may reduce the patient's perception of pain.

### **INTERVENTIONS**

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients: If the level of the patient's head is greater than that of the

torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.
5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.
6. When a pregnant patient in the third trimester is placed in axial spinal stabilization, place in the left lateral position to decrease pressure on the Inferior Vena Cava.
7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

#### **LIMITED ALS INTERVENTIONS**

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



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## ADULT RESPIRATORY EMERGENCIES

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### **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

Chronic symptoms of pulmonary disease, wheezing, cough, pursed lip breathing, decreased breath sounds. Accessory muscle use, anxiety, ALOC or cyanosis.

#### **BLS INTERVENTIONS**

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, obtain O<sub>2</sub> saturation on room air, or on home O<sub>2</sub> if possible.

#### **LIMITED ALS INTERVENTIONS**

1. Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O<sub>2</sub> saturation on room air or on home O<sub>2</sub> if possible.
2. Nebulized Albuterol 2.5mg, with Atrovent 0.5mg may repeat times two (2).

### **ACUTE ASTHMA/BRONCHOSPASM**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

History of prior attacks, associated with wheezing, diminished breath sounds, or cough. A history of possible toxic inhalation, associated with wheezing, diminished breath sounds, or cough. Suspected allergic reaction associated with wheezing, diminished breath sounds or cough.

#### **BLS INTERVENTIONS**

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, humidified oxygen preferred.

**LIMITED ALS INTERVENTIONS**

1. Maintain airway with appropriate adjuncts, obtain O<sub>2</sub> saturation on room air if possible.
2. Nebulized Albuterol 2.5mg, with Atrovent 0.5mg may repeat times two (2).
3. For signs of inadequate tissue perfusion, initiate IV bolus of 300cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
4. If no response to Albuterol, give Epinephrine 0.3mg (1:1,000) SC. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
5. May repeat Epinephrine 0.3mg (1:1,000) SQ after 15 minutes.
6. Base station physician may order additional medications or interventions as indicated by patient condition.

**ACUTE PULMONARY EDEMA/CHF****FIELD ASSESSMENT/TREATMENT INDICATORS**

History of cardiac disease, including CHF, and may present with rales, occasional wheezes, jugular venous distention and/or peripheral edema.

**BLS INTERVENTIONS**

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask.
3. Be prepared to support ventilations as clinically indicated.

**LIMITED ALS INTERVENTIONS**

1. Maintain airway with appropriate adjuncts, Obtain O<sub>2</sub> saturation on room air if possible
2. Nitroglycerine 0.4mg sublingual/transmucosal with signs of adequate tissue perfusion. May be repeated as long as patient continues to have signs of adequate tissue perfusion. Do not use or discontinue NTG in presence of hypotension (SBP <100).

3. Nebulized Albuterol 2.5 mg, with Atrovent 0.5 mg may repeat times two (2), if nitro is not working.



## **AIRWAY OBSTRUCTION - ADULT**

### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Universal sign of distress.
2. Alteration in respiratory effort and/or signs of obstruction.
3. Altered level of consciousness.

### **BLS INTERVENTION - RESPONSIVE**

1. Assess for ability to speak or cough (e.g. "Are you choking?").
2. If unable to speak, administer abdominal thrusts/Heimlich maneuver or chest thrusts for pregnant or obese patients until the obstruction is relieved or patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC's.
4. Administer oxygen therapy; if capable obtain O2 saturation, per Protocol Reference #10170, Pulse Oximetry.
5. If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

### **BLS INTERVENTION - UNRESPONSIVE**

1. Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
2. Open airway with, head tilt-chin lift (for suspected trauma use jaw thrust). Remove object if visible. Assess for presence and/or effectiveness of respiration for no more than ten (10) seconds.
3. If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise, reposition airway and reattempt.
4. If apneic and able to ventilate, provide one (1) breath every five (5) to six (6) seconds.

5. If unable to ventilate, check for pulse then initiate CPR according to AHA 2005 guidelines and check for pulse every two (2) minutes until obstruction is relieved or able to ventilate.
6. If available, place AED per Protocol Reference #10130 AEMT.

**LIMITED ALS INTERVENTION – UNRESPONSIVE**

1. If apneic and able to ventilate, establish advanced airway.
2. Establish vascular access as indicated.



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## **NON-TRAUMATIC HYPERTENSIVE CRISIS**

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### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Headache, blurred vision.
2. Neurological deficit.
3. Altered level of consciousness.
4. Chest pain, dyspnea.
5. Pulmonary edema.
6. Abrupt elevation of diastolic blood pressure.

### **CONTRAINDICATIONS**

Nitroglycerin is contraindicated for use in a hypertensive crisis of unknown etiology.

### **BLS INTERVENTIONS**

1. Reduce anxiety; allow patient to assume position of comfort and elevate head slightly.
2. Administer oxygen as clinically indicated; prepare to support ventilations as clinically indicated.
3. Consider transport to closest hospital or ALS intercept.

### **LIMITED ALS INTERVENTIONS**

1. Maintain airway with appropriate adjuncts.
2. Obtain oxygen saturation on room air, if possible, unless detrimental to patient condition.
3. Obtain vascular access -- saline lock preferred.
4. Contact Base Station.



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## SUSPECTED ACUTE MI

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### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Chest Pain (Typical or Atypical).
2. Syncopal episode.
3. History of previous AMI, Angina, Heart Disease, or other associated risk factors.

### BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI.
2. Reduce anxiety, allow patient to assume position of comfort.
3. O<sub>2</sub> as clinically indicated.
4. Obtain Oxygen saturation.
5. May assist patient with self-administration of Nitroglycerin and Aspirin.

### LIMITED ALS INTERVENTIONS

1. Aspirin 162mg.
2. Consider early vascular access.
3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300ml NS bolus, may repeat.
4. Nitroglycerin 0.4mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. Nitroglycerin is contraindicated (signs of inadequate tissue perfusion or recent use of sexual enhancement medications).
5. Consider establishing a saline lock enroute on same side as initial IV.
6. Complete thrombolytic checklist, if time permits.
7. Contact Base Station.





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## CARDIAC ARREST - ADULT

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### FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

### BLS INTERVENTIONS

1. Assess patient, begin CPR according to current AHA Guidelines and maintain appropriate airway.
  - a. Compression rate shall be 100/minute utilizing 30:1 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
  - b. Ventilatory volumes shall be sufficient to cause adequate chest rise.
2. Place AED and follow Protocol Reference #10130 AEMT. CPR is **not** to be interrupted except briefly for rhythm assessment.

### LIMITED ALS INTERVENTIONS

1. Initiate CPR while applying the AED.
2. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.
3. Establish peripheral intravenous access and administer a 300ml bolus, with signs and symptoms of inadequate tissue perfusion, may repeat fluid bolus.
4. Reference Protocol 12010 AEMT Determination of Death policy.

### Utilize the following treatment modalities while managing the cardiac arrest patient:

1. Obtain blood glucose, if indicated; administer Dextrose 50% 25gms IV.
2. Naloxone 2.0mg IM/IN for suspected opiate overdose.

**NOTE**

Base station contact is required to terminate resuscitative measures.



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## ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES

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### 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.

### LIMITED ALS INTERVENTIONS (ADULT)

1. Obtain vascular access.
2. Obtain blood glucose. If hypoglycemic administer:
  - a. Dextrose 25 Grams (50cc) IV 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. If suspected narcotic overdose administer:

- a. Naloxone 2mg IM/IN.
  - b. Repeat Naloxone 2mg IM/IN every 2-3 minutes if needed.
4. Assess and document response to therapy.
  5. Base Station may order additional medication dosages and fluid bolus.

**LIMITED ALS INTERVENTIONS (PEDIATRIC)**

1. Obtain vascular access.
2. Obtain blood glucose.
3. Glucagon 0.5mg IM/IN < 1year of age.
4. Glucagon 1.0mg IM/IN > 1 year of age.
5. Naloxone 0.1mg/kg IM/IN (maximum of 2mg). Repeat dose ever 2-3minutes.



## BURNS – ADULT 15 Years of Age and Older

Any burn patient meeting Burn Classifications requires expeditious packaging, communication and transportation to the closest most appropriate receiving hospital.

### FIELD ASSESSMENT/TREATMENT INDICATORS

Burn Criteria and Destination Policy #8030

### ADULT TREATMENT PROTOCOL: BURNS

Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> <li>• Assess environment and extrication as indicated</li> <li>• Break contact with causative agent (stop the burning process)</li> <li>• Ensure patient airway, protecting cervical spine as indicated</li> <li>• Remove clothing and jewelry quickly, if indicated</li> <li>• Ensure initial assessment</li> <li>• Oxygen and/or ventilate as needed, O<sub>2</sub> saturation (if BLS equipped)</li> <li>• Axial spinal stabilization as appropriate</li> <li>• Treat other life threatening injuries</li> <li>• Control obvious bleeding</li> <li>• Keep patient warm</li> <li>• Estimate % TBSA burned and depth using the “Rule of Nines”               <ul style="list-style-type: none"> <li>○ An individual’s palm represents 1% of TBSA and can be used to estimate scattered, irregular burns</li> </ul> </li> <li>• Transport to ALS intercept or to the closest most appropriate receiving hospital</li> <li>• Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced airway as indicated</li> </ul> <p><b>Airway Stabilization:</b>        Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.</p> <ul style="list-style-type: none"> <li>• Monitor ECG</li> <li>• IV Access: Warm IV fluids when avail</li> </ul> <p><i>Unstable:</i>        BP&lt;90mmHG and/or signs of inadequate tissue perfusion, start 2<sup>nd</sup> IV access.</p> <ul style="list-style-type: none"> <li>○ IV NS 250ml boluses, may repeat to a maximum of 1000ml.</li> </ul> <p><i>Stable:</i>        BP&gt;90mmHG and/or signs of adequate tissue perfusion.</p> <ul style="list-style-type: none"> <li>○ IV NS 500ml/hour</li> </ul>

BLS Continued

Limited ALS Continued

- Transport to appropriate facility:  
*Minor Burn Classification:* transport to the closest most appropriate receiving hospital.  
*Moderate Burn Classification:* transport to the closest most appropriate receiving hospital.  
*Major Burn Classification:* transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).  
*CTP with associated burns:* transport to the most appropriate trauma hospital.
- Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be **considered** for transport to the closest most appropriate Burn Center. Trauma base station contacted shall be made.

**MANAGE SPECIAL CONSIDERATIONS:**

**MANAGE SPECIAL CONSIDERATIONS:**

**Thermal Burns:** Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.

**Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.

**Tar Burns:** Cool with water, do not remove tar.

**Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.

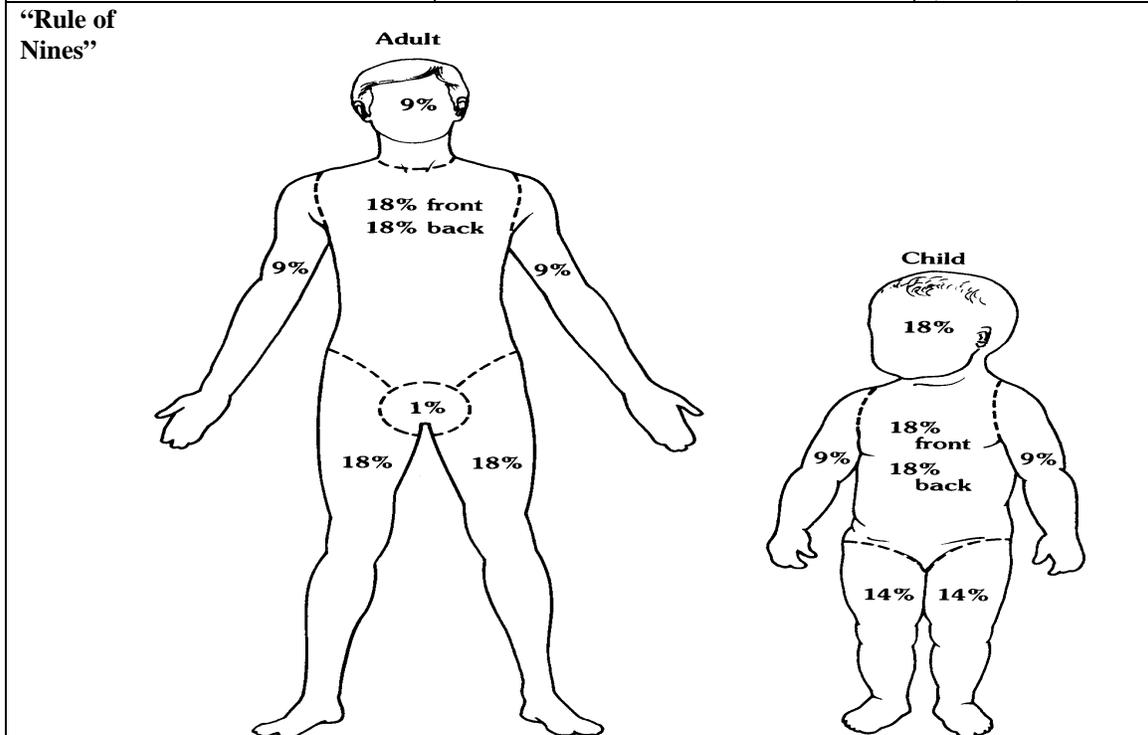
**Electrical Burns:** Place AED according to ICEMA protocols.

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



**BURN CLASSIFICATIONS**

ADULT BURN CLASSIFICATION CHART	PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
<p><b><u>MINOR</u> – ADULT</b></p> <ul style="list-style-type: none"> <li>• &lt; 10% TBSA</li> <li>• &lt; 2% Full Thickness</li> </ul>	<p><b><u>MINOR</u> - PEDIATRIC</b></p> <ul style="list-style-type: none"> <li>• &lt; 5% TBSA</li> <li>• &lt; 2% Full Thickness</li> </ul>	<p><b>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</b></p>
<p><b><u>MODERATE</u> – ADULT</b></p> <ul style="list-style-type: none"> <li>• 10 - 20% TBSA</li> <li>• 2 - 5% Full Thickness</li> <li>• High Voltage Injury</li> <li>• Suspected Inhalation Injury</li> <li>• Circumferential Burn</li> <li>• Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)</li> </ul>	<p><b><u>MODERATE</u> - PEDIATRIC</b></p> <ul style="list-style-type: none"> <li>• 5 – 10% TBSA</li> <li>• 2 – 5% Full Thickness</li> <li>• High Voltage Injury</li> <li>• Suspected Inhalation Injury</li> <li>• Circumferential Burn</li> <li>• Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)</li> </ul>	<p><b>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</b></p>
<p><b><u>MAJOR</u> – ADULT</b></p> <ul style="list-style-type: none"> <li>• &gt;20% TBSA burn in adults</li> <li>• &gt; 5% Full Thickness</li> <li>• High Voltage Burn</li> <li>• Known Inhalation Injury</li> <li>• Any significant burn to face, eyes, ears, genitalia, or joints</li> </ul>	<p><b><u>MAJOR</u> - PEDIATRIC</b></p> <ul style="list-style-type: none"> <li>• &gt; 10% TBSA</li> <li>• &gt; 5% Full Thickness</li> <li>• High Voltage Burn</li> <li>• Known Inhalation Injury</li> <li>• Any significant burn to face, eyes, ears, genitalia, or joints</li> </ul>	<p><b>CLOSEST MOST APPROPRIATE BURN CENTER</b></p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>





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## WITHHOLDING RESUSCITATIVE MEASURES

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### PURPOSE

To establish criteria for withholding resuscitative measures from person(s) who do not otherwise meet the “Determination of Death” criteria in the prehospital setting and/or during interfacility transport.

### AUTHORITY

Division 2.5, Sections 1797.220 and 1798 of the California Health and Safety Code.

### POLICY

The DNR only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement.

### DEFINITIONS

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

1. Chest compressions,
2. Defibrillation,
3. Endotracheal intubation,
4. Assisted ventilation,
5. Cardiotonic drugs, e.g., epinephrine, atropine or other medications intended to treat a non-perfusing rhythm.

**Absent vital signs:** Absence of respiration and absence of carotid pulse.

**DNR medallion/bracelet/necklace:** A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA).

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

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

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

## VALIDATION CRITERIA

1. **Statewide Prehospital DNR Form** (Appendix A) should include the following to be considered valid:
  - a. Patient's name.
  - b. Signature of the patient or a legal representative if the patient is unable to make or communicate informed health care decisions.
  - c. Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
  - d. All signatures are to be dated.
  - e. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.
2. **DNR medallion/bracelet/necklace:** The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:

- a. Patient must be physically wearing the DNR medallion/bracelet/necklace.
  - b. Medallion/bracelet/necklace must be engraved with the words “Do Not Resuscitate EMS”, along with a toll free emergency information telephone number and a patient identification number.
3. **Physician DNR orders:** In licensed health care facilities a DNR order written by a physician shall be honored. The staff must have the patient’s chart with the DNR order immediately available for EMS personnel upon their arrival.
  4. **POLST:** The POLST form must be signed and dated by a physician. **Without this signature, the form is invalid.** Verbal or telephone orders are valid if allowed by the institution or facility. There should be a box checked indicating who the physician discussed the POLST orders with. By signing the form, the physician acknowledges that these orders reflect the wishes of the patient or designated decision maker.

## PROCEDURE

1. EMS personnel shall validate the DNR request or POLST form.
2. BLS personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.
3. Limited ALS personnel shall contact a Base Station for direction if a DNR or POLST cannot be validated. While Limited ALS personnel are contacting the Base Station for direction, BLS treatment must be initiated. If contact cannot be made, resuscitative efforts shall continue.
4. If a patient states he/she wishes resuscitative measures, the request shall be honored.
5. If a family member requests resuscitative measures despite a valid DNR or POLST, continue resuscitative measures until Base Station contact is made.
6. If patient is not in cardiac arrest and has a valid POLST form, EMS may provide comfort measures as described in section B of the form.
7. The patient shall be transported to the hospital if comfort measures are started by EMS.
8. Any questions about transporting the patient will be directed to the Base Station.
9. If a patient expires at home, law enforcement must be notified.

10. If a patient expires in a licensed health care facility, the facility has the responsibility to make the appropriate notification.
11. All circumstances surrounding the incident shall be documented on the patient care record. If prehospital personnel are unable to copy the DNR or POLST form the following shall be documented on the patient care record:
  - a. Presence of DNR or POLST form.
  - b. Date of order.
  - c. Name of physician who signed form.
12. A copy of the patient care report and DNR or POLST must be forwarded to ICEMA within one (1) week by either the PLN at the receiving facility if it is a Base Station or by the EMT-P's Agency EMS/QI Coordinator.

#### **SUPPORTIVE MEASURES**

1. Medical interventions that may provide for the comfort, safety and dignity of the patient should be utilized.
2. The patient should receive palliative treatment for pain, dyspnea, major hemorrhage or other medical conditions.
3. Allow any family members/significant others to express their concerns and begin their grieving process.



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## POISONINGS

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### PRIORITIES

1. Assure the safety of EMS personnel.
2. Assure and maintain ABCs.
3. Determine degree of physiological distress.
4. Obtain vital signs, history and complete physical assessment including the substance ingested, the amount, the time substance was ingested and the route.
5. Bring ingested substance to the hospital with patient.
6. Expeditious transport.

### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Altered level of consciousness.
2. Signs and symptoms of substance ingestion, inhalation, injection or surface absorption.
3. History of substance poisoning.

### DEFINITIVE CARE

1. Assure and maintain ABCs.
2. Place patient on high flow oxygen as clinically indicated.
3. Contact poison control (1-800-222-1222).
4. Obtain accurate history of incident:
  - a. Name of product or substance.
  - b. Quantity ingested, and/or duration of exposure.

- c. Time elapsed since exposure.
  - d. Pertinent medical history, chronic illness, and/or medical problems within the last 24 hours.
  - e. Patient medication history.
- 5. Monitor vital signs.
  - 6. Expeditious transport.

**LIMITED ALS SUPPORT PRIOR TO BASE STATION CONTACT**

- 1. Assure and maintain ABC's.
- 2. Oxygen therapy as clinically indicated, obtain oxygen saturation on room air, unless detrimental to patient condition.
- 3. Obtain vascular access at a TKO rate or if hypotensive administer 500cc fluid challenge to sustain a systolic B/P greater than 90mmHg. For pediatric patients with a systolic B/P less than 80mmHg give 20cc/kg IVP and repeat as indicated.
- 4. Charcoal 50gms for adult (pediatrics 1gm/kg). Administer P.O. if alert with a gag reflex. Charcoal is contraindicated with caustic ingestions.



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## HEAT RELATED EMERGENCIES

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### **MINOR HEAT ILLNESS SYNDROMES**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Environmental conditions.
2. Postural hypotension.
3. Dehydration.
4. Heat cramps.

#### **BLS INTERVENTIONS**

1. Remove patient from heat source, position with legs elevated and begin cooling measures.
2. Oxygen as clinically indicated.
3. Rehydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated.

### **HEAT EXHAUSTION**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Dehydration.
2. Elevated temperature, vomiting, hypotension, diaphoresis, tachycardia and tachypnea.
3. No change in LOC.

#### **BLS INTERVENTIONS**

1. Remove patient from heat source, position with legs elevated and begin cooling measures.

2. Oxygen as clinically indicated.
3. Rehydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated.

### **LIMITED ALS INTERVENTIONS**

1. Obtain vascular access.
  - a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains less than 90mmHg.
  - b. Pediatric patients less than nine (9) years of age: Initial 20cc/kg IV bolus; may repeat until palpable pulse obtained.
2. Obtain blood glucose and provide treatment as clinically indicated.
3. Base Station may order additional fluid boluses.

### **HEAT STROKE**

#### **FIELD ASSESSMENT/ TREATMENT INDICATORS**

1. Hyperthermia.
2. ALOC or other signs of central nervous system dysfunction.
3. Absence or presence of sweating.
4. Tachycardia, Hypotension.

#### **BLS INTERVENTIONS**

1. Remove from heat source, position with legs elevated and begin cooling measures.
2. Rapid cooling measures including cold packs placed adjacent to large superficial vessels.
3. Evaporative cooling measures. Avoid oral intake if patient has altered level of consciousness.
4. Oxygen as clinically indicated.

### LIMITED ALS INTERVENTIONS

1. Obtain vascular access.
  - a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains less than 90mmHg.
  - b. Pediatric patients less than nine (9) years of age: Initial 20cc/kg IV bolus; may repeat until palpable pulse obtained.
2. Obtain blood glucose and provide treatment as clinically indicated.
3. Seizure precautions refer to Protocol Reference #11080 AEMT, Altered Level of Consciousness/Seizures, or Protocol Reference #14060 AEMT, Pediatric Seizure, if seizures occur.
4. Contact Base Station for destination and further treatment orders.



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## COLD RELATED EMERGENCIES

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### **SUSPECTED FROSTBITE**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Areas of skin that are cold, white, and hard to touch.
2. Pain to affected extremity.

#### **BLS INTERVENTIONS**

1. Elevate extremity.
2. Do not rub or otherwise attempt active warming.
3. Protect affected body part from further exposure by wrapping in dry sterile gauze.

#### **LIMITED ALS INTERVENTIONS**

Obtain vascular access.

### **MILD HYPOTHERMIA**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Decreased core temperature.
2. Cold, pale extremities.
3. Shivering, reduction in fine motor skills.
4. Loss of judgment and/or altered level of consciousness or simple problem solving skills.

#### **BLS INTERVENTIONS**

1. Oxygen as clinically indicated.
2. Remove from cold/wet environment; remove wet clothing and dry patient.

3. Insulate and apply wrapped heat packs, if available, to groin, axilla and neck. This process should not be interrupted during transport.

### **LIMITED ALS INTERVENTIONS**

1. Obtain vascular access. (Apply AED).
2. Consider blood glucose determination and provide treatment as clinically indicated.

### **SEVERE HYPOTHERMIA**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

1. Severe cold exposure or any prolonged exposure to ambient temperatures below 36 degrees with the following indications:
  - a. Altered LOC with associated behavior changes.
  - b. Unconscious.
  - c. Lethargic.
2. Shivering is generally absent.
3. Blood pressure and heart sounds may be unobtainable.

#### **BLS INTERVENTIONS**

1. Maintain appropriate airway with oxygen as clinically indicated (warm, humidified if possible).
2. Assess carotid pulse for a minimum of 1-2 minutes. If no pulse palpable, place AED if available, per Protocol Reference #10130 AED. If no shock advised, begin CPR.
3. Insulate to prevent further heat loss.
4. Gently cut away wet clothing if transport time is greater than 30 minutes.

#### **LIMITED ALS INTERVENTIONS**

1. Advanced airway as clinically indicated.
2. Obtain vascular access and administer fluid bolus.

- a. Nine (9) years and older: 300ml warmed NS, may repeat.
  - b. Birth to eight (8) years: 20ml/kg warmed NS, may repeat.
3. Contact Base Station.



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## ALLERGIC REACTIONS – ANAPHYLAXIS

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### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Signs and Symptoms of an Acute Allergic Reaction.
2. History of Exposure to Possible Allergen.

### BLS INTERVENTIONS

1. Recognize s/s of respiratory distress for age.
2. Reduce anxiety, assist patient to assume POC.
3. Oxygen administration as clinically indicated, (humidified oxygen preferred).
4. Assist patient with self-administration of prescribed Epinephrine device.

### LIMITED ALS INTERVENTIONS - ADULT

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
2. Epinephrine (1:1,000) 0.3mg SQ. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
3. Nebulized Albuterol 2.5mg with Atrovent 0.5mg via handheld nebulizer for wheezing. May repeat times two (2).
4. Establish peripheral intravenous access. If patient's systolic blood pressure <90mm Hg, then given a bolus of 500ml normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.

### LIMITED ALS INTERVENTIONS – PEDIATRIC (Less than 15 years of age)

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
2. Nebulized Albuterol 2.5 mg with Atrovent 0.5mg - may repeat times two (2).

- a. 1 Day to 12 months – Atrovent 0.25mg
- b. 1 year to 14 years – Atrovent 0.5mg
3. If no response to Albuterol and Atrovent, consider Epinephrine (1:1,000) 0.01mg/kg SC not to exceed adult dosage of 0.3mg. (with Base Station contact).
4. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20ml/kg of NS not to exceed 300ml NS and repeat as indicated.
5. Establish additional IV access if indicated.
6. Base Station may order additional medication dosages and additional fluid boluses.



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## OBSTETRICAL EMERGENCIES

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### **UNCOMPLICATED DELIVERY**

#### **BLS INTERVENTIONS**

1. Administer Oxygen as clinically indicated.
2. Prepare for delivery.
3. Massage fundus if placenta delivered.

### **COMPLICATED DELIVERY**

#### **BLS INTERVENTIONS**

1. Excessive vaginal bleeding prior to delivery:
  - a. Attempt to contain bleeding. Do not place anything into vagina.
  - b. Trendelenburg position.
2. Prolapsed Cord:
  - a. Hips elevated.
  - b. Gently push presenting part of head away from cord.
  - c. Consider knee/chest position for mother.
3. Post Partum Hemorrhage:
  - a. Massage fundus to control bleeding.
  - b. Encourage immediate breast feeding.
  - c. Trendelenburg position.
4. Cord around infant's neck.
  - a. Attempt to slip cord over head.

- b. If unable to slip cord over head, deliver the baby through the cord.
  - c. If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps.
5. Breech presentation and head not delivered within 3-4 minutes:
- a. Hi-flow O2 on patient.
  - b. Trendelenburg position.
  - c. Code 3 to closest appropriate facility.
6. Pregnancy induced hypertension and Eclampsia:
- a. Seizure precautions.
  - b. Attempt to reduce stimuli.
  - c. Limit fluid intake.
  - d. Monitor and document B/P.
  - e. Consider left lateral position.

### **LIMITED ALS INTERVENTIONS**

1. Obtain IV access, and maintain IV rate as appropriate.
2. Excessive vaginal bleeding or post-partum hemorrhage.
  - a. Give fluid challenge of 500ml, if signs of inadequate tissue perfusion persist may repeat fluid bolus.
  - b. Maintain IV rate at 150ml/hr.
  - c. Establish 2nd large bore IV enroute.
3. Pregnancy Induced Hypertension / Eclampsia.
  - a. IV TKO, limit fluid intake.
  - b. Obtain O2 saturation on room air, if possible.

- c. Place in left lateral position, and obtain BP after five (5) minutes.
4. Consider immediate notification of Base Station physician.



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## NEWBORN CARE

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### FIELD ASSESSMENT/TREATMENT INDICATORS

Field delivery with or without complications.

### BLS INTERVENTIONS

1. When head is delivered, suction mouth then the nose, and check to see that cord is not around baby's neck.
2. Dry infant and provide warm environment. Prevent heat loss (remove wet towel).
3. Place baby in supine position at or near the level of the mother's vagina. After pulsation of cord has ceased double clamp cord at approximately 7" and 10" from baby and cut between clamps.
4. Maintain airway, suction mouth and nose.
5. Provide tactile stimulation to facilitate respiratory effort.
6. Assess breathing if respirations <20 or gasping, provide tactile stimulation and assisted ventilation if indicated.
7. Circulation:
  - a. Heart Rate <100 ventilate BVM with 100% O<sub>2</sub> for 30 seconds and reassess. Repeat if HR remains <100.
  - b. Heart Rate <60 begin chest compressions (rate 120 times/min) and provide BVM ventilation at a rate of 40-60 breaths/min with 100% O<sub>2</sub>, reassess.
8. Central cyanosis is present, utilize supplemental O<sub>2</sub> at 10 to 15L/min using oxygen tubing close to infant's nose and reassess. If no improvement is noted after 30 seconds assist ventilation with BVM
9. Obtain Apgar scoring at one (1) and five (5) minutes. Do not use Apgar to determine need to resuscitate.

**APGAR SCORE**

<b>SIGN</b>	<b>0</b>	<b>1</b>	<b>2</b>
<b>Heart Rate</b>	Absent	< 100/minute	> 100/minute
<b>Respirations</b>	Absent	<20/irregular	>20/crying
<b>Muscle Tone</b>	Limp	Some Flexion	Active Motion
<b>Reflex Irritability</b>	No Response	Grimace	Cough or Sneeze
<b>Color</b>	Blue or pale	Blue Extremities	Completely Pink

**LIMITED ALS INTERVENTIONS**

1. Obtain vascular access via IV if indicated.
2. Obtain Blood Glucose by heel stick.
3. Contact Base Station if hypovolemia is suspected. Base Station may order 10-20ml/kg IV NS over 5 minutes. If unable to contact Base Station and transport time is extended give 10ml/kg IV NS over 5 minutes, may repeat.



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## **SUSPECTED SUDDEN INFANT DEATH SYNDROME INCIDENT**

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### **PURPOSE**

It is imperative that all prehospital personnel in ICEMA be able to assist the caregiver and local police agencies during a suspected SIDS Incident.

### **PROCEDURE**

1. Follow individual department/agency policies at all times.
2. Ask open-ended questions about incident.
3. Explain what you are doing, the procedures you will follow, and the reasons for them.
4. If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
5. Provide the parent/caregiver with the number of the California SIDS Information Line:

1-800-369-SIDS (7437)

6. Provide psychosocial support and explain the emergency treatment and transport of their child.
7. Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.



## TRAUMA - ADULT (15 Years of Age and Older)

Any critical trauma patient (CTP) requires expeditious packaging, communication and transportation to the most appropriate trauma hospital. In Inyo and Mono Counties, the assigned base station should be contacted. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.

### FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030 AEMT

### ADULT TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> <li>• Assess environment and extrication as indicated</li> <li>• Ensure thorough initial assessment</li> <li>• Ensure patent airway, protecting cervical spine</li> <li>• Axial spinal stabilization as appropriate</li> <li>• Oxygen and/or ventilate as needed, O<sub>2</sub> saturation (if BLS equipped)</li> <li>• Control obvious bleeding</li> <li>• Keep patient warm</li> <li>• For a traumatic full arrest, an AED may be utilized, if indicated</li> <li>• Transport to ALS intercept or to the closest most appropriate receiving hospital</li> <li>• Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced airway as indicated</li> </ul> <p><b>Unmanageable Airway:</b>        Transport to the closest most appropriate receiving hospital when the patient requires advanced airway:</p> <ul style="list-style-type: none"> <li>• An adequate airway cannot be maintained with a BVM device</li> </ul> <ul style="list-style-type: none"> <li>• Apply AED</li> <li>• IV Access: Warm IV fluids when avail</li> </ul> <p><i>Unstable:</i>        BP&lt;90mmHG and/or signs of inadequate tissue perfusion, start 2<sup>nd</sup> IV access.</p> <p><i>Stable:</i>        BP&gt;90mmHG and/or signs of adequate tissue perfusion.</p> <p><b>Blunt Trauma:</b></p> <p><i>Unstable:</i> IV NS open until stable or 2000ml maximum is infused</p> <p><i>Stable:</i> IV NS TKO</p>



**BLS Continued**

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

**Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

**Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

**Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

**Limited ALS Continued**

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

- Administer IV NS 250ml bolus one time.

**Impaled Object:** Remove object upon trauma base physician order, if indicated.

<u><i>BLS Continued</i></u>	<u><i>Limited ALS Continued</i></u>
<p><b>Pregnancy:</b> Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females <math>\geq</math> 24 weeks of gestation.</p> <p><b>Traumatic Arrest:</b> CPR if indicated. May utilize an AED if indicated.</p> <p><b>Determination of Death on Scene:</b> Refer to Protocol # 12010 AEMT, Determination of Death on Scene.</p>	<p><b>Traumatic Arrest:</b> Continue CPR as appropriate.</p> <ul style="list-style-type: none"><li>• Monitor V-Fib or V-tach, defibrillate as per ACLS guidelines and ICEMA protocols.</li></ul> <p><b>Determination of Death on Scene:</b> Refer to Protocol # 12010 AEMT, Determination of Death on Scene.</p> <p><b>-Severe Blunt Force Trauma Arrest:</b> <b>IF INDICATED:</b> transport to the closest receiving hospital.</p> <p><b>-Penetrating Trauma Arrest:</b> <b>IF INDICATED:</b> transport to the closest receiving hospital.</p> <ul style="list-style-type: none"><li>• If the patient does not meet the “Obvious Death Criteria” in the “<i>Determination of Death on Scene</i>” Protocol #12010 AEMT, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.</li><li>• Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact.</li></ul> <p><b>Precautions and Comments:</b></p> <ul style="list-style-type: none"><li>○ Electrical injuries that result in cardiac arrest shall be treated as medical arrests.</li><li>○ Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.</li></ul>

	<p><b><u>Limited ALS Continued</u></b></p> <ul style="list-style-type: none"><li>○ If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.</li><li>○ <b>Unsafe scene may warrant transport despite low potential for survival.</b></li><li>○ Whenever possible, consider minimal disturbance of a potential crime scene.</li></ul> <p><b>Base Station Orders:</b> May order additional:</p> <ul style="list-style-type: none"><li>• fluid boluses.</li></ul>
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**REFERENCE PROTOCOLS**

**Protocol**

**Number**

9010 AEMT  
10160 AEMT  
10010/10020 AEMT  
11070 AEMT  
15030 AEMT  
12010 AEMT

**Protocol Name**

General Patient Care Guidelines  
Axial Spinal Stabilization  
King Airway Device  
Adult Cardiac Arrest  
Trauma Triage Criteria and Destination Policy  
Determination of Death on Scene



## TRAUMA - PEDIATRIC (Less Than 15 Years of Age)

Any critical trauma patient (CTP) requires expeditious packaging, communication and transportation to the most appropriate trauma hospital. In Inyo and Mono Counties, the assigned base station should be contacted. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.

### FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030

### PEDIATRIC TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> <li>• Assess environment and extrication as indicated</li> <li>• Ensure thorough initial assessment</li> <li>• Ensure patient airway, protecting cervical spine</li> <li>• Axial spinal stabilization as appropriate</li> <li>• Oxygen and/or ventilate as needed, O<sub>2</sub> saturation (if BLS equipped)</li> <li>• Control obvious bleeding</li> <li>• Keep patient warm and reassure</li> <li>• For a traumatic full arrest, an AED may be utilized, if indicated</li> <li>• Transport to ALS intercept or to the closest most appropriate receiving hospital</li> <li>• Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances.</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced airway as indicated</li> </ul> <p><b>Unmanageable Airway:</b>        Transport to the closest most appropriate receiving hospital when the patient requires an advance airway:        An adequate airway cannot be maintained with a BVM device.</p> <ul style="list-style-type: none"> <li>• Apply AED</li> <li>• IV Access: Warm IV fluids when avail</li> </ul> <p><i>Unstable:</i>        Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2<sup>nd</sup> IV access.        o Administer 20ml/kg NS bolus IV, may repeat once.</p> <p><i>Stable:</i>        Vital signs (age appropriate) and/or signs of adequate tissue perfusion.        o <i>Maintain</i> IV NS rate at TKO.</p>

<u><i>BLS Continued</i></u>	<u><i>Limited ALS Continued</i></u>
<p><b>MANAGE SPECIAL CONSIDERATIONS:</b></p> <p><b>Abdominal Trauma:</b> Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.</p> <p><b>Amputations:</b> Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.</p> <ul style="list-style-type: none"><li>• <b>Partial amputation:</b> Splint in anatomic position and elevate the extremity.</li></ul> <p><b>Blunt Chest Trauma:</b> If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.</p> <p><b>Flail Chest:</b> Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.</p> <p><b>Fractures:</b> Immobilize above and below the injury. Apply splint to injury in position found except:</p>	<ul style="list-style-type: none"><li>• Transport to appropriate hospital: PEDS patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closes trauma hospital.</li></ul> <p><b>MANAGE SPECIAL CONSIDERATIONS:</b></p> <p><b>Fractures:</b></p> <p><b>Isolated Extremity Trauma:</b> Trauma <u>without multisystem mechanism.</u></p>

**BLS Continued**

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

**Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

**Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

**Limited ALS Continued**

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

- Administer 20ml/kg NS bolus IV one time.

- Base Station Orders:

**BLS Continued**

**Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

**Pediatric Patients:** If the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

**Traumatic Arrest:** CPR if indicated. May utilize an AED if indicated.

**Determination of Death on Scene:** Refer to Protocol # 12010 AEMT, Determination of Death on Scene.

**Limited ALS Continued**

**Impaled Object:** Remove object upon trauma base physician order, if indicated.

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

- Apply AED follow instructions.

**Determination of Death on Scene:** Refer to Protocol # 12010 AEMT, Determination of Death on Scene.

**-Severe Blunt Force Trauma Arrest:**  
**IF INDICATED:** transport to the closest receiving hospital.

**-Penetrating Trauma Arrest:**  
**IF INDICATED:** transport to the closest receiving hospital.

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

	<p><u>Limited ALS Continued</u></p> <ul style="list-style-type: none"> <li>• Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact.</li> </ul> <p><b>Precautions and Comments:</b></p> <ul style="list-style-type: none"> <li>○ Electrical injuries that result in cardiac arrest shall be treated as medical arrests.</li> <li>○ Confirm low blood sugar in children and treat as indicated with altered level of consciousness.</li> <li>○ Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.</li> <li>○ <b>Unsafe scene may warrant transport despite low potential for survival.</b></li> <li>○ Whenever possible, consider minimal disturbance of a potential crime scene.</li> </ul> <p><b>Base Station Orders:</b> May order additional:</p> <ul style="list-style-type: none"> <li>• fluid boluses.</li> </ul>
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**REFERENCE PROTOCOLS**

**Protocol Number**

9010 AEMT  
10160 AEMT  
10010/10020 AEMT  
14040 AEMT  
15030 AEMT  
12010 AEMT

**Protocol Name**

General Patient Care Guidelines  
Axial Spinal Stabilization  
King Airway Device  
Pediatric Cardiac Arrest  
Trauma Triage Criteria and Destination Policy  
Determination of Death on Scene