



**INYO COUNTY**  
**EMERGENCY MEDICAL CARE COMMITTEE**



**Bishop Training Center**  
**960 Poleta Rd**  
**Bishop, CA 93514**

**HOSTED BY:**  
**Northern Inyo Hospital**

**July 25, 2011**  
**QI Committee – Cancelled**  
**EMCC -- 6:00 p.m.**

**A G E N D A**

**I. CALL TO ORDER**

**II. APPROVAL OF MAY 23, 2011 MINUTES**

**ACTION**

**III. ICEMA UPDATE**

**INFO/ACTION**

- A. Legislation Update
- B. Data System RFP
- C. Paramedic Scope of Practice
- D. Upcoming CQI Project - Pediatric Intubation

**IV. EMS SYSTEM MANAGEMENT REPORTS**

**INFO/ACTION**

- A. Base Hospital Report
- B. Scantron/ePCR Report

**V. OLD BUSINESS**

**INFO/ACTION**

**VI. NEW BUSINESS**

**ACTION/APPROVE**

- A. Update of Health Hazard Vulnerability Assessment
- B. Inyo County Field Treatment Site Plan
- C. Obligations/Expectations of the Base Station Regarding EMT Training and Clinical Contacts
- D. Ambulance Rate Changes
- E. Inyo County Status for MCI Training
- F. AEMT Program Update
- G. Inyo Policy Clarification for Protocol Reference #s:
  - 1. 6100 Stroke Receiving Centers
  - 2. 8100 Continuation of Trauma Run
  - 3. 11110 Stroke Treatment Policy

- H. General Protocols
  - 1. 1040 Requirements for EMT -P Accreditation
  - 2. 1060 Certification Accreditation Review Policy
  - 3. 3010 Annual Review Class (ARC)
  - 4. 5030 Procedure for Adoption of Protocols and Policies
  - 5. 6030 AED Service Provider Policy - Public Safety
  - 6. 6040 Lay Rescuer AED Implementation Guidelines
  - 7. 7030 Controlled Substance Policy
  - 8. 8030 Burn Destination and Criteria Policy
  - 9. 8060 San Bernardino County Requests for Hospital Diversion Policy
  - 10. 8080 Bed Delay Patient Destination Policy
  - 11. 9110 Treatment of Patients with Airborne Infections and Transport Recommendations
  - 12. 10060 Needle Thoracostomy
  - 13. 10070 Needle Cricothyrotomy
  - 14. 10110 Transcutaneous Cardiac Pacing
  - 15. 10120 Synchronized Cardioversion
  - 16. 10130 Automatic External Defibrillation (AED)-BLS
  - 17. 11020 Airway Obstruction - Adult
  - 18. 11040 Bradycardias - Adult
  - 19. 11050 Tachycardias - Adult
  - 20. 11060 Suspected Acute MI
  - 21. 11070 Cardiac Arrest - Adult
  - 22. 11090 Shock (Non-Traumatic)

- I. Advanced EMT Protocols

- 1. 7010 AEMT ALS and BLS, Standard Drug and Equipment List
- 2. 9010 AEMT General Patient Guidelines
- 3. 9020 AEMT Physician on Scene
- 4. 9030 AEMT Responsibility for Patient Management
- 5. 9040 AEMT Reporting Incidents of Suspected Abuse Policy
- 6. 9050 AEMT Organ Donor Information
- 7. 9060 AEMT Local Medical Emergency
- 8. 9070 AEMT Applying Patient Restraints Guidelines
- 9. 9080 AEMT Care of Minors in the Field
- 10. 9090 AEMT Patient Refusal of Care Guidelines – Adult
- 11. 10010 AEMT King Airway Device (Perilaryngeal) – Adult
- 12. 10020 AEMT King Airway Device (Perilaryngeal) – Pediatric
- 13. 10130 AEMT Automatic External Defibrillation (AED)
- 14. 10160 AEMT Axial Spinal Stabilization
- 15. 10160 AEMT Axial Spinal Stabilization
- 16. 11010 AEMT Respiratory Emergencies – Adult
- 17. 11020 AEMT Airway Obstructions – Adult
- 18. 11030 AEMT Non-traumatic Hypertensive Crisis
- 19. 11060 AEMT Suspected Acute MI
- 20. 11070 AEMT Cardiac Arrest – Adult
- 21. 11080 AEMT Altered Level of Consciousness/Seizures – Adult

22. 11100 AEMT Burns – Adult
23. 12010 AEMT Determination Of Death on Scene
24. 12020 AEMT Withholding Resuscitative Measures
  - EMSA Do Not Resuscitate (DNR) Report Form
  - ICEMA Do Not Resuscitate (DNR) Report Form
25. 13010 AEMT Poisonings
26. 13020 AEMT Heat Related Emergencies
27. 13030 AEMT Cold Related Emergencies
28. 14030 AEMT Allergic Reactions – Pediatric
29. 14080 AEMT Obstetrical Emergencies
30. 14090 AEMT Newborn Care
31. 14100 AEMT Suspected Sudden Infant Death Syndrome Incident
32. 15010 AEMT Trauma – Adult
33. 15020 AEMT Trauma – Pediatric

**VII. OTHER/PUBLIC COMMENT**

**VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**

**IX. NEXT MEETING DATE AND LOCATION**

**X. ADJOURNMENT**

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



**INYO COUNTY EMCC MEETING**  
**Big Pine Fire Department, 181 North Main Street, Big Pine CA 93513**

**Hosted by:**  
**Big Pine Fire Department**  
**MINUTES**  
**May 23, 2011**

**Voting Members Present:**

Judd Symons, Vice Chair	Symons Emergency Specialties, Inc.	<a href="mailto:juddsymons@aol.com">juddsymons@aol.com</a>
Le Roy Kritz	Lone Pine Fire Department, Chief	<a href="mailto:LChief2401@lonepinetv.com">LChief2401@lonepinetv.com</a>
Lloyd Wilson	Big Pine Fire Department	<a href="mailto:dlwilson41@msn.com">dlwilson41@msn.com</a>
Mike Patterson	Sierra Life Flight, Program Director	<a href="mailto:mike@sierraaviation.com">mike@sierraaviation.com</a>
Andrew Stevens	Northern Inyo Hospital	<a href="mailto:Andrew.stevens@nih.org">Andrew.stevens@nih.org</a>

**Voting Members Absent:**

Martha Reynolds	Northern Inyo Hospital	<a href="mailto:marthareynolds@nih.org">marthareynolds@nih.org</a>
Lee Barron	Southern Inyo Hospital	<a href="mailto:leebee40@aol.com">leebee40@aol.com</a>
Joe Cappello	Independence Fire Department	<a href="mailto:jcappello@cebridge.net">jcappello@cebridge.net</a>
Paul Postle, Chairperson	So. Inyo Fire Prot. District, Chief	<a href="mailto:paul2701@wildblue.net">paul2701@wildblue.net</a>
Dr. Michael Dillon	ER Physician	<a href="mailto:MichaelDillon@qnet.com">MichaelDillon@qnet.com</a>
Dr. Rick Johnson	Inyo County Public Health	<a href="mailto:drerrickjohn@gmail.com">drerrickjohn@gmail.com</a>
Phil Ashworth	Independence Fire Department	<a href="mailto:philinyo@usamedia.tv">philinyo@usamedia.tv</a>
Steven Davis	Olanca Cartago Fire Dept., Chief	<a href="mailto:olanchafire@aol.com">olanchafire@aol.com</a>

**Other Attendees:**

Jean Turner	Health & Human Services, Director	<a href="mailto:jturner@inyocounty.us">jturner@inyocounty.us</a>
John Marzano	Big Pine Fire Department	<a href="mailto:bigpinepeaches@yahoo.com">bigpinepeaches@yahoo.com</a>
Lisa Erwin	Northern Inyo Hospital	<a href="mailto:Lisa.Erwin@NIH.org">Lisa.Erwin@NIH.org</a>
Marty Fortney	Inyo County Supervisor	<a href="mailto:mfortney@inyocounty.us">mfortney@inyocounty.us</a>
Paul Easterling	ICEMA	<a href="mailto:peasterling@cao.sbcounty.gov">peasterling@cao.sbcounty.gov</a>
Ray G. Seguire	Bishop Fire Department	<a href="mailto:Seguire@ca-bishop.us">Seguire@ca-bishop.us</a>
David Calloway	Big Pine Fire Department	
Melissa Best-Baker	Inyo County HHS/Public Health	<a href="mailto:mbestbaker@inyocounty.us">mbestbaker@inyocounty.us</a>
Gerry Tanksley	Inyo County HHS/Public Health	<a href="mailto:gtanksley@inyocounty.us">gtanksley@inyocounty.us</a>
Steve Patraw	Boundtree	<a href="mailto:spatraw@boundtree.com">spatraw@boundtree.com</a>
Fred Hawkins	Liberty Ambulance	<a href="mailto:flhawkins8@aol.com">flhawkins8@aol.com</a>

**I. CALL TO ORDER**

Chairperson, Judd Symons called the meeting to order at 6:15 p.m.

**II. APPROVAL OF MARCH 28, 2011 MINUTES**

Motion made by Andrew Stevens, seconded by Lloyd Wilson to approve the minutes of the March 28, 2011. Motion carried unanimously.

### **III. ICEMA UPDATE**

#### **A. QI Plan**

Provider template will be released to enable providers to plug the information into the form. ICEMA will have what indicators they want and locals can add their own indicators.

#### **B. Intubation CQI Project**

This QI project will be used to address the necessity of pediatric intubations. Doctors have been pushing to get rid of pediatric intubations. EMS wants to keep pediatric intubations.

Nasotracheal intubations will probably be discontinued. Pediatric intubations will probably require more frequent trainings and have a requirement of end title CO2 via Capnography. All pediatric intubations will be reviewed.

#### **C. Data System RFP**

Six companies submitted proposals. After several days of demonstrations and proposal evaluation, Image Trend was chosen. New software will work with the current hardware. The new software won't be in place for at least a year.

### **IV. EMS SYSTEM MANAGEMENT REPORTS**

#### **A. Base Hospital Report**

Nothing to report

#### **B. Scantron/ePCR Report**

Each agency received their reports.

### **V. OLD BUSINESS**

Nothing to Report

### **VI. NEW BUSINESS**

#### **A. Proposed 2011-12 Fee Schedule**

Copies were sent to EMS Officers and EMCC members. Some items were increased. Example: Failure to complete re-verification requirements is now \$100.00 per course. Paul Easterling to get clarification on how fees are set, which items increase and why.

**B. Continuation of Trauma Care Protocol**

Just finished the comment period. This protocol was created to ease the concerns of ER doctors regarding stabilizing and then transferring to a trauma center. This protocol does not work in Inyo County. Andrew Stevens to submit comments to ICEMA. There was a discussion that a separate protocol for Inyo and Mono may be necessary.

**C. Neurovascular Stroke Receiving Center Designation Criteria**

This is not applicable in Inyo County. There is not a stroke center in close proximity to either hospital. There was a discussion that a separate protocol for Inyo and Mono may be necessary.

ICEMA can provide Stroke education which includes CEs. It was stated that there is more interest in doing trauma training provided by ICEMA.

The “Stroke Decision Tree” is being laminated and put into ambulances for a reference guide in other counties. It might be considered here in Inyo.

**VII. OTHER/PUBLIC COMMENT**

- A request to appoint Lisa Erwin to the EMCC as a voting member will be going to the Board of Supervisors for approval on June 7, 2011.
- The Maddy funds disbursement approvals will be going to the Board of Supervisors on June 7, 2011. There is no \$ remaining.
- HHS is working with ICEMA on ambulance rates.

**VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING**

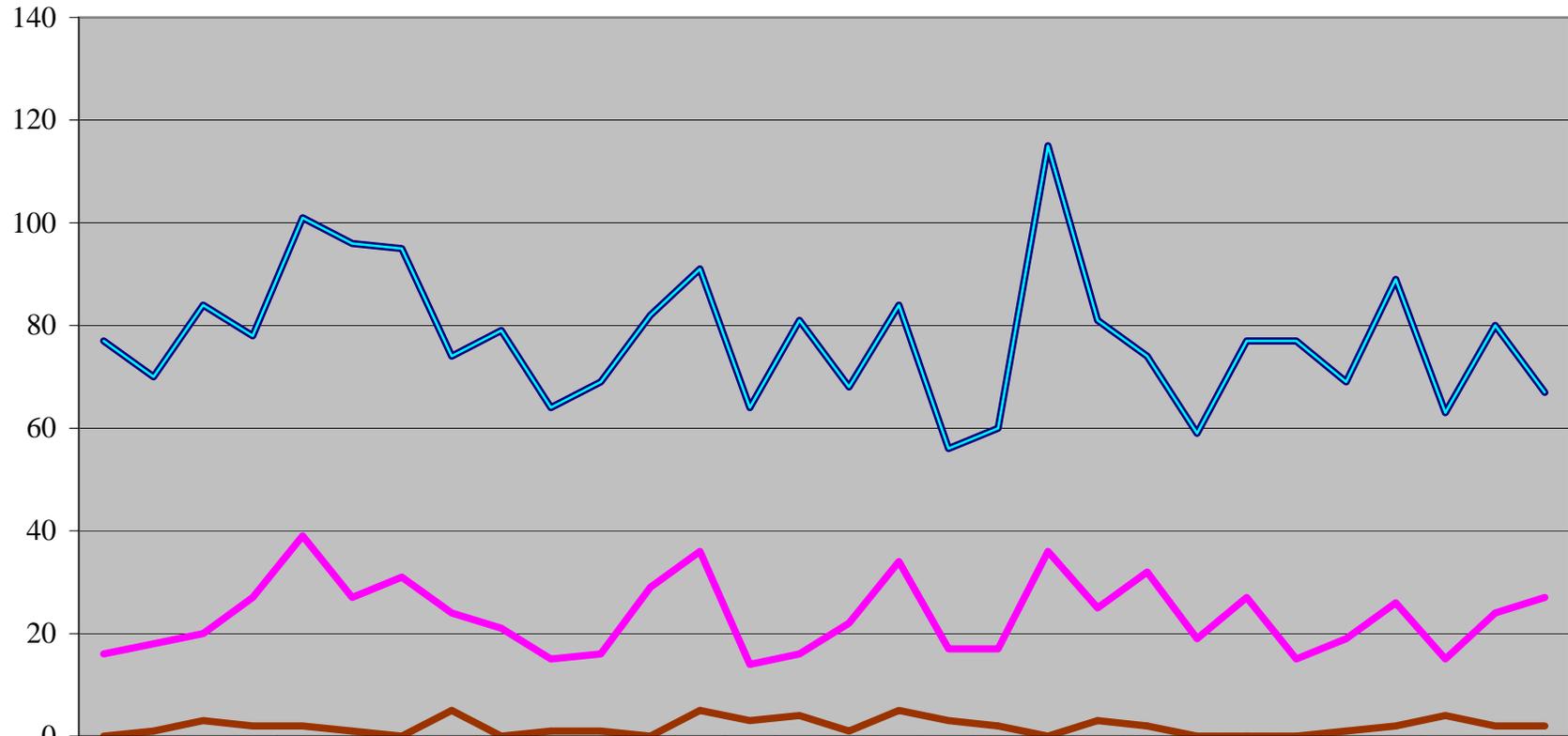
**IX. NEXT MEETING DATE AND LOCATION**

Monday, July 25, 2011 at Bishop Fire Training Center to be hosted by Northern Inyo Hospital. Q.I. 5:00 p.m., EMCC 6:00 p.m.

**X. ADJOURNMENT**

The meeting was adjourned at 6:50 p.m.

## Northern Inyo Base Hospital Statistics Base Hospital Contacts and Patients Received January 2009 - June 2011



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2009												2010												2011					
Contacts	77	70	84	78	101	96	95	74	79	64	69	82	91	64	81	68	84	56	60	115	81	74	59	77	77	69	89	63	80	67
Trauma	16	18	20	27	39	27	31	24	21	15	16	29	36	14	16	22	34	17	17	36	25	32	19	27	15	19	26	15	24	27
Peds	0	1	3	2	2	1	0	5	0	1	1	0	5	3	4	1	5	3	2	0	3	2	0	0	0	1	2	4	2	2
Received	77	70	84	78	101	96	95	74	79	64	69	82	91	64	81	68	84	56	60	115	81	74	59	77	77	69	89	63	80	67

Source: Base hospital self reporting.  
In 6/09 the collection tool was modified to ensure data uniformity.  
Compiled by ICEMA, ME.

# **FIELD TREATMENT SITE PLAN**

**DRAFT  
MAY 2011**



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## Concept of Operations

<b>Duration</b>	1 to 48 Hours
<b>Types of Events</b>	Multi/mass Casualty Event/Incident, such as <ul style="list-style-type: none"> <li>• Earthquake</li> <li>• Bomb blast</li> <li>• Transportation accident</li> <li>• Any event where the local capacity for transporting patients is overwhelmed (per state plan)</li> </ul>
<b>Function</b>	<ul style="list-style-type: none"> <li>• Patient congregation / registration</li> <li>• Triage</li> <li>• Medical care</li> <li>• Patient holding / evacuation</li> </ul>
<b>Scope of Medical Care</b>	<ul style="list-style-type: none"> <li>• EMS medical care (ALS and/or BLS) <ul style="list-style-type: none"> <li>○ Wound care</li> <li>○ Control of bleeding</li> <li>○ Treatment of shock</li> <li>○ Fluid replacement (ALS only - when available)</li> <li>○ Splinting of fractures</li> <li>○ Pain relief (ALS only - when available)</li> <li>○ Initial care of burns</li> </ul> </li> <li>• Mental health support</li> </ul>
<b>Staffing</b>	Staffing provided by EMS personnel, with surge from neighboring jurisdictions, regional support (through ICEMA), Public Health staff (admin), and medical volunteers (DHV)
<b>Location</b>	<ul style="list-style-type: none"> <li>• Near incident site<sup>1</sup></li> <li>• Near hospital</li> <li>• Pre-designated sites geographically and/or strategically located</li> </ul>
<b>Objective</b>	Provide a clear and concise approach for Field Treatment Sites (FTS) that can be dynamically implemented when the field triage and transport needs of a mass casualty incident in Inyo County will surpass one hour.
<b>Assumptions</b>	During an incident lasting more than one hour, it is estimated that there could be between 20-100 casualties needing medical care and/or transportation to a hospital. This will exceed the standard Mass Casualty Incident (MCI) management approach and require a more formal FTS to initially triage and eventually transport the injured casualties to different hospitals and trauma centers. As the FTS is anticipated to be open for no longer than 48 hours, no state or federal support is expected to be available. There may be regional support available from neighboring counties, assuming the event has not affected them to the same degree.

<sup>1</sup> During a localized MCI event (e.g. bus crash, bleacher collapse), the IC, MGS, and MHOAC will determine the optimal location for the FTS. Ideally, it will be located close enough to the event to not require vehicle transportation, but far enough to be independent from the event and its initial triage area. However, in most instances, this will not be possible, and a pre-designated disaster facility will be selected.

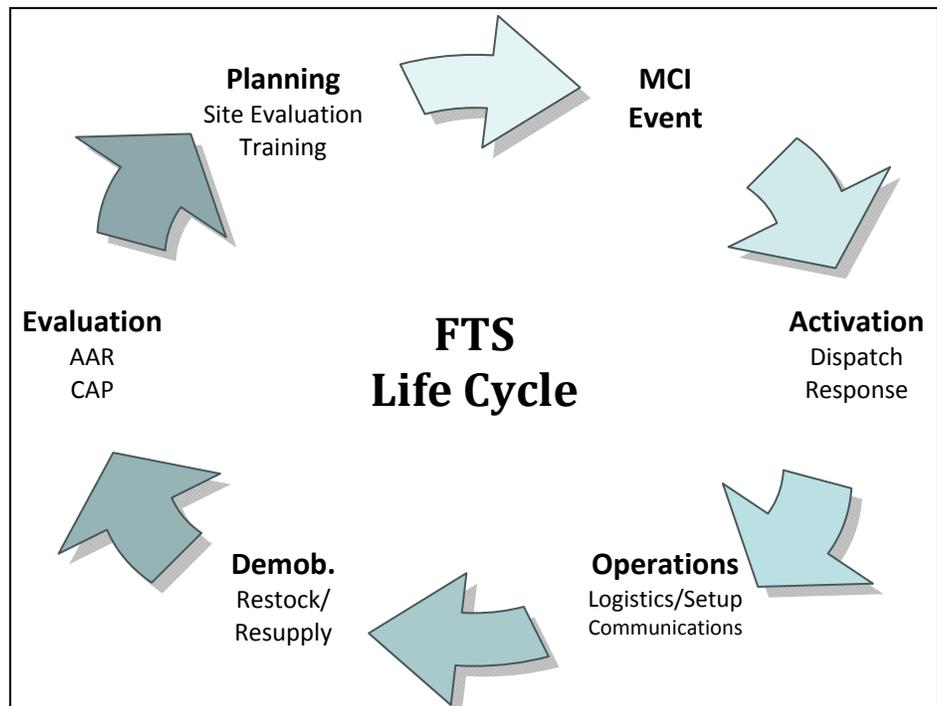
## Executive Summary

The objective of the Field Treatment Site (FTS) plan is to triage and temporarily treat patients until they can be transported to an acute care hospital.

The Inyo County EMCC, the MHOAC, and ICEMA have identified that the existing EMS system can transport up to 20 patients within the first hour of a major event, such as a bomb blast. Therefore, an FTS location is a suitable option when there are expected to be more than 20 patients or there will be delays greater than one hour in removing/extricating patients from the incident. This is very incident dependent, e.g., weather, remote location, etc. An FTS location is meant to be operational for up to 48 hours, at which time planners should consider establishing one or more Alternate Care Sites (ACS) to accommodate the patients for a longer period of time.

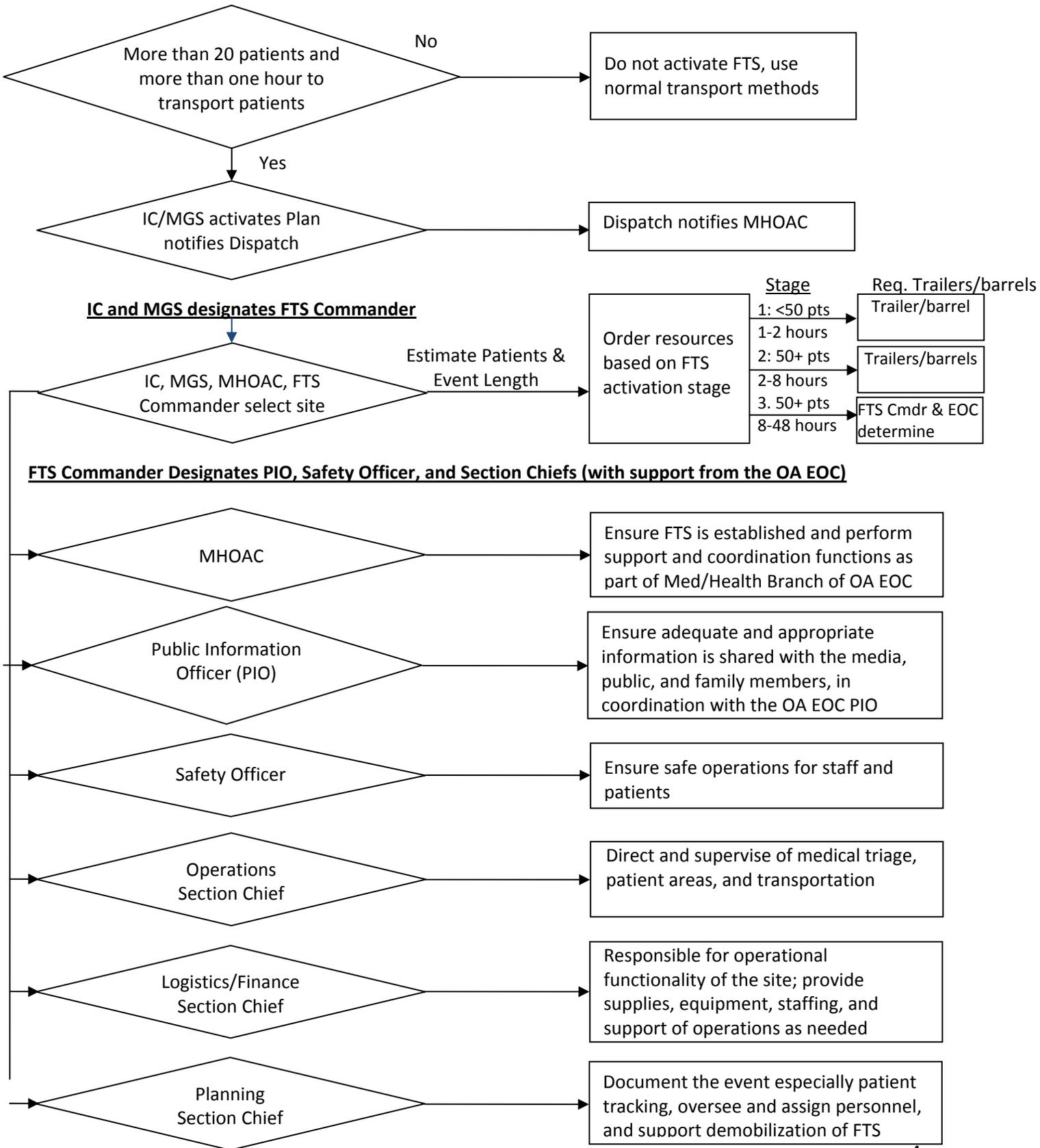
The location of an FTS is dependent on the type of event, on-going threat, weather, and available resources. The scene Incident Commander (IC), the Medical Group Supervisor (MGS), and the FTS Commander (all on-scene) will ultimately select the FTS location. Ideally, this site will be outside the incident area and any hazard zone, but close to enough to carry patients to the FTS triage area (i.e. no ambulance required). However, in most instances, this will not be possible, and a pre-designated disaster facility will be selected (see Appendix 1). The FTS will be supported by the Medical/Health Branch of the Operational Area Emergency Operations Center (OA EOC) through the Medical and Health Operational Area Coordinator (MHOAC) functions.

There are six components to the FTS Plan and its life cycle. During the planning cycle, the existing facilities designated for potential disaster response in Inyo County will be evaluated for their potential use as FTS. EMS and public health officials will train using this plan and incorporate changes as appropriate. When an MCI event occurs, the scene IC will communicate with the Medical Group Supervisor regarding the potential need to activate the FTS plan. Once the need is confirmed, the scene IC and the MGS will activate the FTS plan. This will include appointing a FTS Commander, and notifying dispatch of the selected FTS location. Dispatch will in turn notify the MHOAC. Once activated, the operations cycle begins. The FTS Commander will identify individuals to fill the immediate and secondary roles as staffing permits, request resources as needed, and ensure the rapid triage and transport of patients. The MHOAC role is to provide support and coordination to the FTS Commander. Communications is a crucial element during



this cycle. Once the EMS system regains the ability to transport all patients to hospitals, the demobilization cycle will commence. During this time, all paperwork should be completed, equipment stored, supplies restocked, staff released from their positions, and the location cleaned. When the owner of the FTS location accepts back control of the property, the evaluation cycle begins. An After Action Report (AAR) and subsequent Improvement Plan (IP) are the priorities during this phase of the FTS life cycle. The plan recommendations are incorporated into future training during the planning cycle to prepare Inyo County for the next deployment of the FTS plan.

## Activation Algorithm



**Roles and Responsibilities, utilizing the city and/or OA EOP/EOC, and ICS/SEMS**

Legend: ○ = Support, Coordination, and Involvement ● = Primary Responsibility

FTS Functions	On-Scene Command	City/OA Public Safety Dispatch	Hospitals, Clinics	OA EOC Environmental Health Branch	OA EOC Mental Health Branch	OA EOC Medical/Health Branch (MHOAC)	City/OA EOC Construction and Engineering Branch	City/OA EOC Law Enforcement Branch or Local Law Enforcement	OA EOC Care and Shelter Branch	City/OA EOC Logistics Section	Other
Command and Control (Scene)	●										
Coordination if more than one EMS FTS						●					
Notification		●	○	○	○	○			○	○	
Provision of Personnel		○	○	○	○	○				● <sup>2</sup>	○ <sup>3</sup>
Medical Supply			○			●				○	○ <sup>4</sup>
Medical Equipment			●			●				●	○ <sup>4</sup>
Non-Medical Supply				○						●	○ <sup>4</sup>
Communications Equipment		○								●	○ <sup>4</sup>
Facility Support (utilities)							●			○	
Food									●	○	
Water										●	
Sanitation				○						●	
Child/Companion Animal Care									●		
Security and Perimeter Control							○	●		○	
Level of Care Decisions						●					
Mental Health Counseling			○		●				○		
Infection Control Instructions			○	○		●					
Helicopters			○							●	○ <sup>5</sup>
Alternative Ground Transportation										●	
Public Information	●				○						● <sup>6</sup>

<sup>2</sup> All departments agreeing to provide staffing during the pre-planning phase are listed as support. The lead for filling requests from the field for additional staff will be through the Staffing Unit of the EOC.  
<sup>3</sup> DHV, MRC, CAL-MAT, DMAT, and Federal Health Care workers  
<sup>4</sup> Vendors  
<sup>5</sup> Logistics Air Operations contacts Regional Emergency Operations Center (REOC) for assistance from the National Guard and other military sources.  
<sup>6</sup> Coordination on Public Information should be through the field to the JIC, if established.

## FTS Planning Checklist

**Objective:** Identify the necessary resources and staff to activate and operate an FTS. Evaluate potential sites ahead of time and established agreements as needed

<input type="checkbox"/>	Evaluate existing facilities for potential use as pre-designated FTS locations during a major event, such as an earthquake (use appendix 1: site list and Inyo County Facility Profile)
<input type="checkbox"/>	Establish a Memorandum of Understanding (use Inyo County Draft MOU) with these sites
<input type="checkbox"/>	Create a site plan for these locations, including air/ground transportation access (use appendix 1: site/facility map/floor plan)
<input type="checkbox"/>	Identify equipment necessary to support each FTS
<input type="checkbox"/>	Maintain equipment through regular testing and inspections to support up to two FTS locations
<input type="checkbox"/>	Establish transportation plan/agreement for moving the FTS equipment between locations
<input type="checkbox"/>	Require all personnel that may be placed in a leadership position to attend the appropriate training, e.g. ICS 100/200/300

## FTS Activation Checklist

**Objective:** Establish one or more FTS locations when existing resources will not be able to transport all incident casualties within the first hour of the event.

<b>Scene Incident Commander (IC) and/or Medical Group Supervisor (MGS)</b>	
<input type="checkbox"/>	Activate the FTS Plan
<input type="checkbox"/>	Notify Inyo County Dispatch that the FTS Plan is being activated that there are more patients than can be transported within one hour (e.g. > 20 patients)
<input type="checkbox"/>	Establish communication with the MHOAC
<input type="checkbox"/>	Identify the following:
<input type="checkbox"/>	How many expected casualties and any unique needs (e.g. decon, burns, peds)
<input type="checkbox"/>	Where patients are currently being triaged
<b>Inyo County Dispatch</b>	
<input type="checkbox"/>	Contact the MHOAC, as well as OA Law and Fire Coordinators if not already notified.
<b>Inyo County MHOAC</b>	
<input type="checkbox"/>	Along with the IC, MGS, and FTS Commander, select FTS site(s)
<input type="checkbox"/>	Conduct situational assessment, and provide Situational Reporting according to the California Public Health and Medical Emergency Operations Manual (EOM) policy and procedures
<input type="checkbox"/>	Coordinate the acquisition of needed health and medical resources.
<input type="checkbox"/>	Activate Medical/Health Branch of the OA EOC; virtual, partial, or full as needed
<b>Inyo County Health Department DOC (as part of the Medical/Health Branch of the OA EOC)</b>	
<input type="checkbox"/>	Deploy resources to the FTS locations, including:
<input type="checkbox"/>	trailers, one for each 50 casualties per site
<input type="checkbox"/>	provide personnel to the FTS as requested by the FTS Commander and the MHOAC
<b>FTS Commander</b>	
<input type="checkbox"/>	Contact on scene MGS or designee
<input type="checkbox"/>	Establish FTS location(s) along with the IC, MGS, and MHOAC
<input type="checkbox"/>	Ensure necessary functions are staffed, utilizing the EOC for support and coordination
<input type="checkbox"/>	Determine need for resources, and coordinate requesting, acquisition, and tracking with

EOC
<input type="checkbox"/> Establish and maintain on-site communications with the field level and the OA EOC
<input type="checkbox"/> Assign a Safety Officer
<input type="checkbox"/> Assign a Public Information Officer
<input type="checkbox"/> Assign an Operations Section Chief to accept, triage, treat, and transport casualties
<input type="checkbox"/> Assign a Logistics Section Chief to track resources requested and received
<input type="checkbox"/> Assign a Planning Section Chief to coordinate patient tracking and situation reports
<input type="checkbox"/> Assign a Finance Section Chief to track staff time on-site and ensure patient records tracking and security as per HIPAA
<input type="checkbox"/> If not a pre-designated FTS location, identify a site layout diagram to accommodate triage, patient types, air/ground transportation, equipment, administration, etc.
<input type="checkbox"/> Assign additional positions as needed (use appendix 3: sample organizational charts and job descriptions)

### **FTS Operations Checklist**

**Objective:** Provide for the safe and rapid triage and transport of injured casualties to a definitive level of care

<b>FTS Commander</b>
<input type="checkbox"/> Receive briefings from MGS or designee at the incident
<input type="checkbox"/> Re-estimate the number of expected casualties and any special needs (e.g. decon, peds, burns)
<input type="checkbox"/> Establish a command post/administration area following the site layout diagram
<input type="checkbox"/> Provide briefings to the EOC every hour
<input type="checkbox"/> Establish and maintain communications with MGS and EOC
<b>Operations Section Chief</b>
<input type="checkbox"/> Using the site layout diagram (appendix 2), identify:
<input type="checkbox"/> Casualty reception/triage area
<input type="checkbox"/> Minor injury casualty area – green tarps and tape
<input type="checkbox"/> Delayed injury casualty area – yellow tarps and tape
<input type="checkbox"/> Immediate injury casualty area – red tarps and tape
<input type="checkbox"/> Deceased casualty area – black tarps and tape
<input type="checkbox"/> Air/Ground ambulance transportation ingress and egress
<input type="checkbox"/> Assign a Triage Group Supervisor to rescreen incoming casualties and reprioritize as their conditions may have changed since the initial triage; implement or continue using START tags
<input type="checkbox"/> Assign a Treatment Group Supervisor(s), as needed, to accomplish incident objectives
<input type="checkbox"/> Assign Treatment Team Leaders for minor, delayed, and immediate teams, as needed
<input type="checkbox"/> Assign Transportation Group Supervisor to manage ambulance flow and patient destinations
<input type="checkbox"/> Assign a Morgue Group Supervisor, as needed, to oversee and secure deceased casualties
<input type="checkbox"/> Task medical personnel assigned to FTS Operations
<b>Logistics Section Chief</b>
<input type="checkbox"/> Identify what medical resources are on scene
<input type="checkbox"/> Identify what medical resources have been requested
<input type="checkbox"/> Identify what additional medical resources are necessary and make official request (use

appendix 4: resource inventory)
<input type="checkbox"/> Establish secure area for medical supply cache
<input type="checkbox"/> Identify site needs for up to 48 hour deployment, ONLY if stage 2 or 3 activation
<input type="checkbox"/> Food
<input type="checkbox"/> Water
<input type="checkbox"/> Bathrooms
<input type="checkbox"/> Tents/shelters
<input type="checkbox"/> Generators/fuel
<input type="checkbox"/> Lighting
<input type="checkbox"/> HVAC
<input type="checkbox"/> Consider requesting the American Red Cross for logistical support, specifically food and water for staff and casualties
<b>Planning Section Chief</b>
<input type="checkbox"/> Establish sign-in and out procedures for all personnel assigned to FTS
<input type="checkbox"/> Assign personnel to support FTS operations, logistics, finance, and planning as needed
<input type="checkbox"/> Assign a Document Unit Leader
<input type="checkbox"/> Document patient destinations
<input type="checkbox"/> Prepare Incident Action Plan (IAP)
<input type="checkbox"/> Provide situation reports to FTS Commander
<input type="checkbox"/> Complete and communicate Site Report Form (use appendix 5) to FTS Commander and/or EOC
<input type="checkbox"/> Track needs when the FTS is demobilized
<b>Finance Section Chief</b>
<input type="checkbox"/> Track staff time on-site and ensure patient records tracking and security as per HIPAA

### **FTS Demobilization Checklist**

**Objective:** Turn FTS location back over to responsible party in the same and better condition and ensure all FTS, staff, and patient documentation is provided to the EOC

<b>Logistics Section Chief</b>
<input type="checkbox"/> Clean non-disposable FTS supplies and repack for storage
<input type="checkbox"/> Arrange for transportation of FTS resources back to their storage locations
<input type="checkbox"/> Used disposable medical supplies should be disposed of properly
<input type="checkbox"/> Arrange for removal of trash and biohazard waste
<input type="checkbox"/> Ensure facility is clean and left in the same or better condition
<input type="checkbox"/> Ensure staff have adequate and appropriate mental health debriefing and counseling
<b>Planning Section Chief</b>
<input type="checkbox"/> Ensure all paperwork is completed, especially patient care and destination
<input type="checkbox"/> All FTS, staff, and patient information should be given to the MHOAC
<input type="checkbox"/> Have all FTS staff check-out and report any injuries or other issues needing follow-up
<input type="checkbox"/> Turn facility back over to owner or responsible party after walk-through
<input type="checkbox"/> Prepare After Action Report (AAR)
<b>Finance Section Chief</b>
<input type="checkbox"/> Ensure staff time is reported to the appropriate agency for reimbursement
<input type="checkbox"/> Identify billing and/or cost recovery opportunities for care provided

**Appendix 1: Designated Disaster Facilities and Facility Profile Checklist**

**Inyo County HHS/Public Health Division**

**Designated Disaster Facilities**

**Bishop**

1. Bishop City Hall Auditorium
2. Bishop Airport Hangar
3. Tri County Fairgrounds-Charlie Brown Auditorium
4. Tri County Fairgrounds-Home Economics Building
5. Tri County Fairgrounds-Patio Building
6. Cerro Coso College
7. Inyo County Superintendent of Schools
8. Bishop Union Elementary School District
9. Inyo County Sheriff's Department Posse Hut
10. Bishop Senior Center
11. Calvary Baptist Church
12. Catholic Church
13. Methodist Church
14. Nazarene Church

**Big Pine**

15. Big Pine School
16. Big Pine Town Hall
17. Palisades Glacier High School

**Independence**

18. Owens Valley School
19. Legion Hall

**Lone Pine**

20. Lone Pine Elementary School District
21. Lone Pine High School
22. Statham Hall
23. Lone Pine Fire Department

## **Olancha**

- 24. Olancha Fire Department Facility
- 25. Olancha BLM Fire Station

(Question by Steve Davis – Has the Olancha School been considered? If so, why rejected? If not, contact Lone Pine USD, Matt Kingsley, President of the School Board, at 760-614-0611.

## **Keeler**

- 26. DWP-Lake Operation Building

## **Round Valley**

- 27. Round Valley School

## **Tecopa**

- 28. Tecopa Community Center

## **Armargosa**

- 29. Armargosa Opera House

## **Shoshone**

- 30. Death Valley Unified School District/Shoshone
- 31. Tecopa Francis

## **Death Valley**

- 32. Nation Park Service Auditorium
- 33. Death Valley Elementary School

## Facility Profile Checklist

**Facility Profile for Use as Field Treatment Site (FTS), Alternate Care Site (ACS), Point of  
Dispensing (POD), and/or Shelter**

**Inspected By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### General

Type of Facility (circle): aircraft hanger, church, community/recreation center, long-term care facility, hospital, clinic, fairgrounds, local government building, military facility, private building, hotel/motel, meeting hall, school, sports facility/stadium, trailer/tent, other (describe):

\_\_\_\_\_

Site Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physical Address (#, street, town, zip):

\_\_\_\_\_

Major cross street/highway: \_\_\_\_\_

GIS Coordinates: \_\_\_\_\_

Proximity (miles) to nearest hospital: \_\_\_\_\_ police station: \_\_\_\_\_ fire station: \_\_\_\_\_

Local EMS Provider: \_\_\_\_\_

Located on flood plain (circle): Y N UNK

Year Built: \_\_\_\_\_ If before 1933, earthquake retrofitted (circle): Y N

Owner: \_\_\_\_\_ MOU in place (circle): Y N Not needed

Is there the potential for mixed usage during a disaster (the owner plus the responding agency)(circle)? Y N

Has the facility been identified for use at the time of a disaster by other agencies (circle)? Y N

Who? \_\_\_\_\_



**Assessment of the Exterior of the Site**

- |  |   |   |
|--|---|---|
| 1. Is vehicle or pedestrian access to the facility perimeter controllable by a fence, wall, or other physical barrier (preferably at least 4 feet high)? | Y | N |
| 2. If Yes, is a gate solid and able to be securely locked?   | Y | N |
| 3. Is there a potential helicopter landing zone nearby?  | Y | N |
| 4. Are there external hazards potentially useful to intruders (hiding places, items that could be used as weapons, missiles, or tools)?                  | Y | N |
| 5. Is there a parking lot?   | Y | N |
| a. # of spaces _____   |   |   |
| b. # of marked ADA spaces meeting ADA requirements: _____  |   |   |
| 6. Is there ADA access to the building (ramp, etc.)?   | Y | N |
| 7. Is there adequate access and entry for emergency vehicles with a gurney?  | Y | N |
| 8. Is there a separate loading dock/area?  | Y | N |
| 9. Are there forklifts or pallet jacks available (if Yes, circle which and indicate #): _____  | Y | N |
| 10. Is there access to the loading dock/area for a semi-trailer truck (18 wheeler)?  | Y | N |
| 11. Is the responsibility for potential snow removal assigned?   | Y | N |
| 12. Does flooding ever interfere with access to the parking and facility?  | Y | N |
| 13. Is there the ability to lock down the building (all entrances/exits/windows)?  | Y | N |
| 14. External lighting:   |   |   |
| a. Is the entire perimeter lighted?  | Y | N |
| b. Is the parking area adequately lighted?   | Y | N |
| c. Is the exterior of the building, especially entry points, adequately lighted?   | Y | N |
| d. Are control switches for external lighting automatic (versus manual)?   | Y | N |
| e. Are control switches inaccessible to unauthorized persons?  | Y | N |
| f. Do any exterior lights have an auxiliary power source?  | Y | N |
| g.   |   |   |

15. Describe access to the parking lot and main entrance from major roads?

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16. Can all street/road/highway access to the site be blocked off if necessary?      Y      N

17. Could a secure route be ensured for access by supply or emergency vehicles?      Y      N

18. Are there any facilities nearby which might pose a security threat (jail, halfway house, storage of hazardous materials, bars)?      Y      N

Describe:

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19. Are there any problems with vehicular traffic congestion in the area?      Y      N

Describe:

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20. Briefly describe the type of neighborhood (i.e., residential, commercial, industrial):

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Based upon this assessment of the **exterior** of the site, the suitability of this site to support the

indicated emergency response is:

FTS (circle):                      Low      Average                      High

ACS (circle):                      Low      Average                      High

POD/RSS (circle):              Low      Average                      High

Shelter long term (circle):      Low      Average                      High

Shelter short term (circle):      Low      Average                      High

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Comments (narrative):

**Assessment of the Interior of the Site**

1. Are all exterior doors solid core wood, metal clad, or metal? Y N
2. Are all exterior doors equipped with cylinder locks, deadbolts, or solid locks? Y N
3. Are all exterior doors equipped with intrusion alarms? Y N
  - a. Where does the alarm system terminate (circle): commercial law enforcement
4. Is the main power source dependable? Y N
  - a. Utility company (circle): SCE DWP
5. Is there an auxiliary power source/generator? Y N
  - a. # watts: \_\_\_\_\_
  - b. # gallons of fuel on hand: \_\_\_\_\_
  - c. # hours of operation without additional fuel: \_\_\_\_\_
6. Is there (circle): heat, A/C, hot water, propane tank on the premises?
7. Is interior lighting adequate in all anticipated workplaces for safe movement/tasks? Y N
8. Are light switches key controlled? Y N
9. When was the facility last inspected by the fire marshal? \_\_\_\_\_
10. Did the fire marshal approve the building? Y N
  - a. If no, why not? \_\_\_\_\_
11. Does the building have functioning fire alarms? Y N
12. Does the building have functioning smoke detectors? Y N
13. Does the building have a sprinkler system? Y N
14. Does the building have fire extinguishers? Y N
  - a. If Yes, last inspected: \_\_\_\_\_
15. Does the building have emergency fire hoses/standpipes? Y N
16. Does the building have a functioning and inspected AED? Y N
17. Does the building have any first aid supplies? Y N

18. Is there a written evacuation plan (fire, flood, earthquake, etc.) for the facility? Y N
19. Are exits clearly marked? Y N
20. Describe communications resources:
- PA system, intercom, overhead paging (describe):  
\_\_\_\_\_
  - Internet – none, dial-up, broadband, Wi-Fi (circle all that are available)
  - Computers available for emergency response personnel use (#): \_\_\_\_\_
  - Phone (# lines, phones, TDD capable):  
\_\_\_\_\_
  - FAX (# machines): \_\_\_\_\_
  - During tests, did 2-way radios transmit and receive clearly from inside the building?  
Y N
21. What is the total square footage of the building? \_\_\_\_\_ sq ft
22. What is the total sq ft of the largest room (basketball court = 5,000 sq. ft.)? \_\_\_\_\_ sq ft
23. How many rooms are there in the building? \_\_\_\_\_ rooms
24. According to the fire marshal, what is the maximum occupancy for the building? \_\_\_\_\_ people
25. According to the fire marshal, what is the max occupancy for the largest room? \_\_\_\_\_ people
26. What is the bed capacity of the largest room (50 sq ft per non-ambulatory patient)? \_\_\_\_\_ beds
27. How many stories are there in the building? \_\_\_\_\_ stories
28. Are the doorways ADA accessible from the entrance to the largest room? Y N
29. How many functioning electrical outlets are there in the largest room (#)? \_\_\_\_\_
30. How many restrooms are there (#)? Men: \_\_\_\_\_ Women: \_\_\_\_\_ Unisex: \_\_\_\_\_ ADA:: \_\_\_\_\_
31. How many showers are there (#)? Men: \_\_\_\_\_ Women: \_\_\_\_\_ Unisex: \_\_\_\_\_
32. What is the availability/number of tables: \_\_\_\_\_, chairs: \_\_\_\_\_, room dividers: \_\_\_\_\_?
33. Is there built-in oxygen delivery capability in the facility? Y N
34. Is there a large amount of cash retained in any office overnight, and if so, is there an adequate safe, vault, or strongbox? Y N

35. Are there separate rooms/areas potentially available for the following:

- |                                       |   |   |
|---------------------------------------|---|---|
| a. Staff rest/breakroom               | Y | N |
| b. Kitchen                            | Y | N |
| i. Stove (#): ____                    | Y | N |
| ii. Microwave (#): ____               | Y | N |
| iii. Food supply and preparation area | Y | N |
| iv. Refrigerator (#): ____            | Y | N |
| v. Freezer (#): ____                  | Y | N |
| vi. Sink (#): ____                    | Y | N |
| vii. Dishwasher (#): ____             | Y | N |
| viii. Waste disposal (#): ____        | Y | N |

c. Some or all of the following rooms/areas:

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<u>laundry</u> – separate area or room with washers and dryers	Y	N
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<u>incident manager</u> – separate room able to be secured, with adequate electrical outlets, ability to transmit and receive radio communication, and Internet broadband or wireless communication, with tables or desks and chairs, room for at least 2 workstations	Y	N
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<u>triage</u> – room/area near public entrance, either separate or able to be partitioned off, to setup up at least 2 stations for staff to provide initial evaluation (history, vital signs) of potentially affected individuals ( sick, injured, exposed, contaminated, etc.)	Y	N
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<u>medical counseling</u> – private area/room for medical staff to counsel individuals or families regarding proposed medical intervention (prophy, vacc., Rx, placement)	Y	N
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medical equipment storage – temperature controlled, securable room near loading dock or staff entrance able to store multiple boxes up to the volume of several pallets

Y N

secure pharmaceutical storage – temperature controlled, securable room near loading dock or staff entrance able to store medications, including refrigeration

Y N

isolation - separate room with ability to be separately ventilated (no shared HVAC, open windows OK), ability for privacy and tight control of ingress/egress, ability to move cots, gurney in/out, large enough for at least 5 beds

Y N

palliative care –separate private room large enough for at least 5 cots and family members, able to move cots or gurney in/out

Y N

mortuary – separate secured area for temporary storage of bodies in body bags, near loading dock or staff entrance

Y N

decontamination – location with ability to do decontamination outside (requires ability to set up decon tent with heated water) or inside (showering), while providing privacy, management of biowaste, and protection of non-contaminated individuals (staff and public)

Y N

family – separate private area for families of affected persons to rest, eat, sleep, with shower and bathroom facilities

Y N

media staging – separate area near loading dock/staff entrance, with ability to be securely separated from the public, large enough to conduct interviews/briefings

Y N

service animals/pets – separate room for affected persons with service animals or small pets in cages, kennels, on leash, and well controlled

Y N

environmental supply storage – room/area to store cleaning equipment, bathroom supplies, soap and hand sanitizers, etc., able to be secured      Y      N

lab specimen preparation – secured room/area with table/desk/cabinet/refrigerator suitable for storage of lab equipment (specimen collection) and for packaging and refrigeration of specimens prior to shipment, separate from any food preparation area      Y      N

biohazard/waste disposal – secured room near loading dock or staff entrance able to contain large bags of contaminated waste pending final disposition      Y      N

law enforcement holding – secured private room/area able to temporarily hold individuals being detained by law enforcement      Y      N

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Based on this assessment of the **interior** of the site, the suitability of this site to support the indicated emergency response is:

FTS (circle):	Low	Average	High
ACS (circle):	Low	Average	High
POD/RSS (circle):	Low	Average	High
Shelter long term (circle):	Low	Average	High
Shelter short term (circle):	Low	Average	High

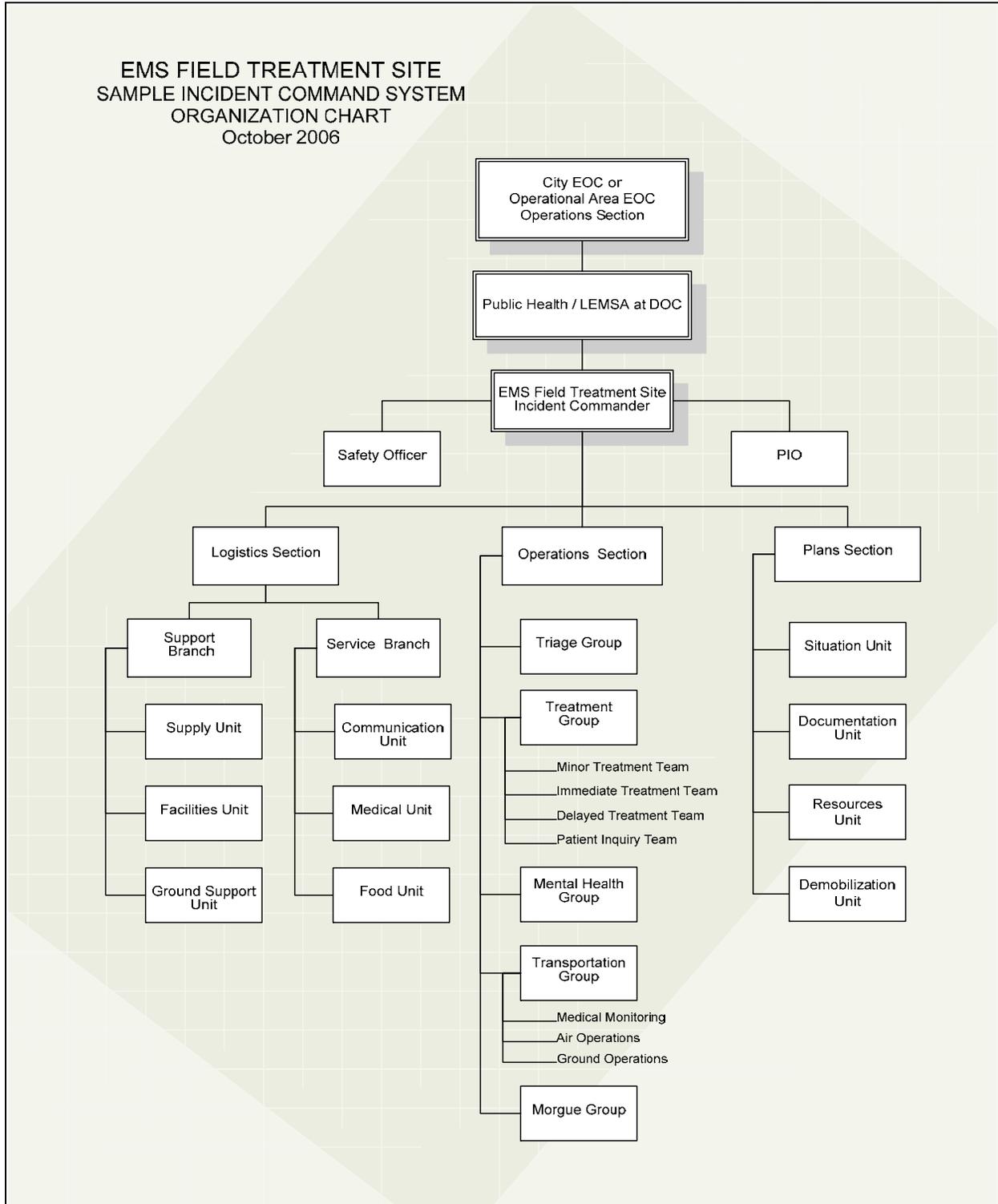
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Comments (narrative):

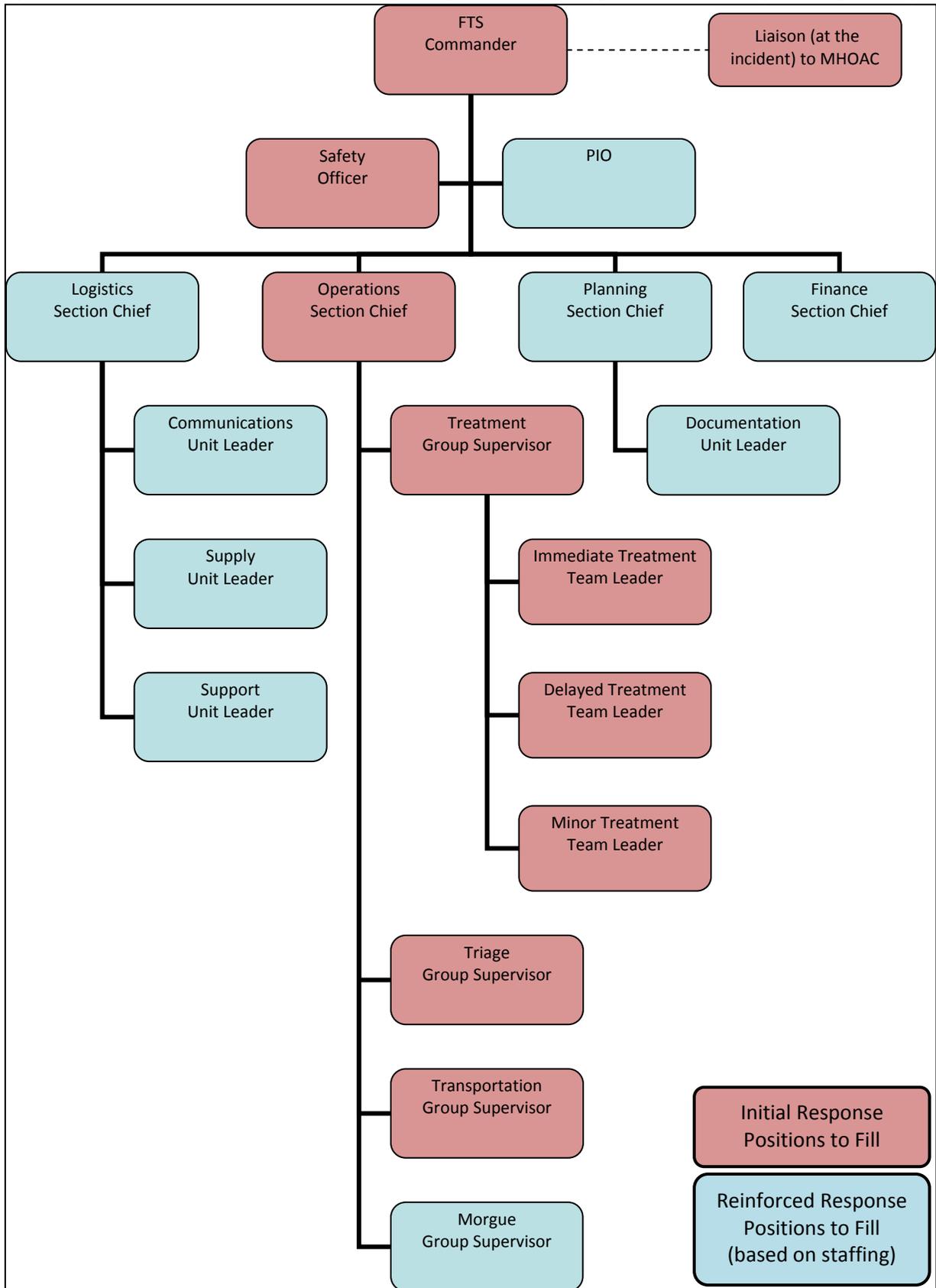
**Site/Facility Map, Floor Plan, Photographs**

Appendix 2: Sample Organizational Charts & Job Descriptions

California EMSA Model - considered ideal model, if resources are available



**Inyo Model - considered min. necessary to open FTS (multiple roles filled by same person)**



JOB ACTION SHEET	MHOAC
<b>FUNCTION:</b>	Ensure FTS is established and maintain on-going communications with IC, MGS, FTS Commander, and DOC/EOC
<b>AGENCY TO FILL JOB:</b>	Public Health, HHS
<b>REPORT TO:</b>	EOC Operations Section Chief or Unified Command
<b>REPORTS TO YOU:</b>	FTS Commander, MGS through liaison or designee
<b>PRIMARY DUTIES:</b>	<b>Activation</b>
	<input type="checkbox"/> Establish contact with MGS and FTS Commander(s)
	<input type="checkbox"/> Work with IC, MGS, and FTS Commander (s) to identify how many FTS are needed and where
	<input type="checkbox"/> Conduct situational assessment, and provide Situational Reporting according to EOM policy and procedures.
	<input type="checkbox"/> Coordinate the acquisition of needed health and medical resources.
	<input type="checkbox"/> Activate Department Operations Center (DOC); virtual, partial, or full as needed (may be the Medical/Health Branch of the EOC if open)
	<b>Operations</b>
	<input type="checkbox"/> Establish and maintain on-going communications between Scene IC, MGS, FTS Commander, DOC/EOC, ICEMA, and Region 6.

<b>JOB ACTION SHEET</b>		<b>FTS COMMANDER</b>
<b>FUNCTION:</b>		Ensure efficient operation of the FTS
<b>AGENCY TO FILL JOB: (1st &amp; 2nd Choice)</b>		EMS Specialist, Public Health, HHS
<b>REPORT TO:</b>		MHOAC, EOC
<b>REPORTS TO YOU:</b>		Safety Officer
		Public Information Officer (PIO)
		Operations Section Chief
		Logistics Section Chief
		Planning Section Chief
		Finance Section Chief
<b>PRIMARY DUTIES:</b>		<b>Activation</b>
ICS Forms	201, 202, 203, 207	<input type="checkbox"/> Establish Incident Action Plan including briefings, objectives, organization assignment list and chart
		<input type="checkbox"/> Confirm incoming resources with DOC/EOC; order additional resources (e.g. trailers) as needed
		<input type="checkbox"/> If not a pre-designated FTS location, identify a site layout diagram to accommodate triage, patient types, air/ground transportation, equipment, administration, etc.
		<input type="checkbox"/> Assign liaison to Scene IC, MGS, and MHOAC, as needed
		<input type="checkbox"/> Assign a Safety Officer
		<input type="checkbox"/> Assign a Public Information Officer
		<input type="checkbox"/> Assign an Operations Section Chief to accept, triage, treat, and transport casualties
		<input type="checkbox"/> Assign a Logistics Section Chief to track resources requested and received
		<input type="checkbox"/> Assign a Planning Section Chief to coordinate patient tracking and situation reports
		<input type="checkbox"/> Assign a Finance Section Chief to track staff time on-site and ensure patient records tracking and security as per HIPAA
Appendix	2	<input type="checkbox"/> Assign additional positions as needed (use appendix 2: sample organizational charts and job descriptions)
		<b>Operations</b>
		<input type="checkbox"/> Re-estimate the number of expected casualties and any special needs (e.g. decon, peds, burns)
		<input type="checkbox"/> Establish a command post/administration area following the site layout diagram
		<input type="checkbox"/> Coordinate with command staff and liaison(s)
ICS Form	214	<input type="checkbox"/> Provide briefings to MHOAC/DOC/EOC as needed

<b>JOB ACTION SHEET</b>		<b>Safety Officer</b>
<b>FUNCTION:</b>		<b>Ensure safe operations for staff and patients</b>
<b>AGENCY TO FILL JOB:</b>		Fire or Law Enforcement, senior personnel
<b>REPORT TO:</b>		FTS Commander
<b>REPORTS TO YOU:</b>		Assistant Safety Officer(s), if any
<b>PRIMARY DUTIES:</b>		<b>Activation</b>
ICS Forms	208, 215A	<input type="checkbox"/> Establish sufficient security to ensure the safety of staff and patients
		<input type="checkbox"/> Identify where supplies and other items needing security are to be stored
		<input type="checkbox"/> Coordinate with local law enforcement when additional security is required

<b>JOB ACTION SHEET</b>	<b>Public Information Officer (PIO)</b>
<b>FUNCTION:</b>	<b>Ensure adequate and appropriate information is shared with the media, public, and family members</b>
<b>AGENCY TO FILL JOB:</b>	HHS, SO
<b>REPORT TO:</b>	FTS Commander
<b>REPORTS TO YOU:</b>	Assistant PIO(s), if any
<b>PRIMARY DUTIES:</b>	<b>Activation</b>
	<input type="checkbox"/> Prepares information for the public regarding the FTS location and care available.
	<input type="checkbox"/> Coordinates and gets approval before release for all messages - with the FTS Commander and/or the JIC, if established.
	<input type="checkbox"/> Escorts media representatives, while protecting patient privacy
	<input type="checkbox"/> May assist with patient inquiries by family members, while protecting patient privacy

<b>JOB ACTION SHEET</b>		<b>Operations Section Chief</b>
<b>FUNCTION:</b>		<b>Direct and supervise of medical triage, patient areas, and transportation</b>
<b>AGENCY TO FILL JOB:</b>		EMS Specialist, Public Health, HHS
<b>REPORT TO:</b>		FTS Commander
<b>REPORTS TO YOU:</b>		Triage Unit Leader
		Treatment Unit Leader
		Transportation Unit Leader
		Medical Group Supervisor, if appointed
<b>PRIMARY DUTIES:</b>		<b>Operations</b>
Appendix	1	<input type="checkbox"/> Using the site layout diagram, identify and supervise: <ul style="list-style-type: none"> <li><input type="checkbox"/> Casualty reception/triage area</li> <li><input type="checkbox"/> Minor injury casualty area - green tarps and tape</li> <li><input type="checkbox"/> Delayed injury casualty area - yellow tarps and tape</li> <li><input type="checkbox"/> Immediate injury casualty area - red tarps and tape</li> <li><input type="checkbox"/> Deceased casualty area - black tarps and tape</li> <li><input type="checkbox"/> Air/Ground ambulance transportation ingress and egress</li> </ul>
ICS Form	215B	<input type="checkbox"/> Establish a Medical Group Supervisor(s), as needed, to accomplish incident objectives <input type="checkbox"/> Establish a Triage Unit Leader to rescreen incoming patients and reprioritize as their conditions may have changed since the initial triage; implement or continue using START tags; assigns infectious individuals to isolation, if an isolation area is available; document patient movement within FTS or assign clerk to manage patient registration and tracking, if available
		<input type="checkbox"/> Establish Treatment Unit Leader, possibly identify separate coordinators for minor, delayed, immediate, and morgue teams, as needed
		<input type="checkbox"/> Establish Team Leaders for each treatment area- Minor, Immediate, and Delayed
		<input type="checkbox"/> Establish Morgue Unit Leader to secure area and coordinate activities with coroner as needed
		<input type="checkbox"/> Establish Ground/Air Transportation Unit Leader (assign subordinate Air Operations Leader, if possible) to manage ambulance flow and assign/document casualty destinations; assign clerk to record patient destinations, if available
		<input type="checkbox"/> Task medical personnel assigned to FTS Operations
ICS Form	214	<input type="checkbox"/> Maintain Activity Log
<b>SECONDARY DUTIES:</b>		<input type="checkbox"/> Establish child care and mental health/quiet areas with appropriate specialists for those uninjured
		<input type="checkbox"/> Establish crisis counseling for patients and stress counseling for staff, possibly request religious staff and children specialists, as needed

<b>JOB ACTION SHEET</b>		<b>Logistics Section Chief</b>
<b>FUNCTION:</b>		<b>Responsible for operational functionality of the site; provide supplies, equipment, staffing, and support of operations as needed</b>
<b>AGENCY TO FILL JOB: (1st &amp; 2nd Choice)</b>		EMS Specialist, Public Health, HHS
<b>REPORT TO:</b>		FTS Commander
<b>REPORTS TO YOU:</b>		Communications Unit Leader
		Supply Unit Leader
		Support Unit Leader
<b>PRIMARY DUTIES:</b>		<b>Operations</b>
		<input type="checkbox"/> Identify what medical resources are on scene
		<input type="checkbox"/> Identify what medical resources have been requested
Appendix	5	<input type="checkbox"/> Identify what additional medical resources are necessary and make official request (use appendix 5: resource inventory)
		<input type="checkbox"/> Establish secure area for medical supply cache
		<input type="checkbox"/> Manage inventory of medical and non-medical supplies
		<input type="checkbox"/> Distribute supplies as requested by Operations
ICS Form	205	<input type="checkbox"/> Ensure all sections can communicate with each other and FTS Commander and Logistics Section Chief can communicate with EOC; provide radio training as needed; consider requesting assistance through EOC for RACES and/or County Dispatch; maintain inventory of equipment used
		<input type="checkbox"/> Determine traffic and patient flow patterns with Operations (assuming not already established in pre-designated FTS location)
		<input type="checkbox"/> In pre-designated FTS location, ensure set-up according to pre-determined layout
		<input type="checkbox"/> Identify site needs for up to 48-hour deployment, ONLY if stage 2 or 3 activation
		<input type="checkbox"/> Food
		<input type="checkbox"/> Water
		<input type="checkbox"/> Bathrooms and sinks
		<input type="checkbox"/> Tents/shelters
		<input type="checkbox"/> Generators/fuel
		<input type="checkbox"/> Lighting
		<input type="checkbox"/> HVAC
		<input type="checkbox"/> Consider requesting the EOC for logistical support, specifically food and water for staff and casualties, as needed
<b>SECONDARY DUTIES:</b>		<b>Demobilization</b>
		<input type="checkbox"/> Clean non-disposable FTS supplies and repack for storage
		<input type="checkbox"/> Arrange for transportation of FTS resources back to their storage locations
		<input type="checkbox"/> Used disposable medical supplies should be disposed of properly
		<input type="checkbox"/> Arrange for removal of trash and biohazard waste
		<input type="checkbox"/> Ensure facility is clean and left in the same or better condition

<b>JOB ACTION SHEET</b>		<b>Planning Section Chief</b>
<b>FUNCTION:</b>		<b>Document the event especially patient tracking, oversee and assign personnel, and support demobilization of FTS</b>
<b>AGENCY TO FILL JOB: (1<sup>st</sup> &amp; 2<sup>nd</sup> Choice)</b>		EMS Specialist, Public Health, HHS
<b>REPORT TO:</b>		FTS Commander
<b>REPORTS TO YOU:</b>		Documentation Unit Leader
<b>PRIMARY DUTIES:</b>		<b>Operations</b>
ICS Form	211	<input type="checkbox"/> Establish sign-in and out procedures for all personnel assigned to FTS
		<input type="checkbox"/> Assign personnel to support FTS operations, logistics, finance, and planning as needed; provide orientation for new arrivals
		<input type="checkbox"/> Appoint a Document Unit Leader
		<input type="checkbox"/> Document patient arrivals in collaboration with Triage Unit Leader or Clerk
		<input type="checkbox"/> Document patient destinations in collaboration with Transport Officer or Clerk
ICS Forms	201, 202, 203, 207	<input type="checkbox"/> Assist FTS Commander prepare an Incident Action Plan (IAP)
		<input type="checkbox"/> Provide situation reports to FTS Commander and to MHOAC
Appendix	5	<input type="checkbox"/> Complete and communicate Site Report Form to FTS Commander and/or DOC
		<input type="checkbox"/> Track needs for when the FTS is demobilized
<b>SECONDARY DUTIES:</b>		<b>Demobilization</b>
		<input type="checkbox"/> Ensure all paperwork is completed, especially patient care and destination
		<input type="checkbox"/> All FTS, staff, and patient information should be given to the EMS agency
		<input type="checkbox"/> Have all FTS staff check-out and report any injuries or other issues needing follow-up
		<input type="checkbox"/> Return all borrowed or rented equipment and unused supplies; reconcile mutual aid resources
		<input type="checkbox"/> Turn facility back over to owner or responsible party after walk-through
ICS Forms	221, 225	<input type="checkbox"/> Prepare Incident Personnel Performance Ratings
		<input type="checkbox"/> Prepare After Action Report (AAR) with MHOAC

<b>JOB ACTION SHEET</b>		<b>Finance Section Chief</b>
<b>FUNCTION:</b>	<b>Track staff time on-site and ensure patient records tracking and security as per HIPAA</b>	
<b>AGENCY TO FILL JOB: (1<sup>st</sup> &amp; 2<sup>nd</sup> Choice)</b>	HHS	
<b>REPORT TO:</b>	FTS Commander	
<b>REPORTS TO YOU:</b>		
<b>PRIMARY DUTIES:</b>	<b>Operations</b>	
	<input type="checkbox"/> Track staff time on-site and ensure patient records tracking and security as per HIPAA	
<b>SECONDARY DUTIES:</b>	<b>Demobilization</b>	
	<input type="checkbox"/> Ensure staff time is reported to the appropriate agency for reimbursement	
	<input type="checkbox"/> Identify billing and/or cost recovery opportunities for care provided	
	<input type="checkbox"/> Approve work necessary to return FTS facility back to pre-incident condition or better	
	<input type="checkbox"/> Turnover FTS financial paperwork to county financial services	

**Additional positions to be appointed as needed, recommended in the Cal EMSA FTS draft plan**

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
<b>Logistics Section</b>			
Facilities Unit Leader/Team	<p>Responsible for operational functionality of the facility. Coordinates with the Support Branch/Supply Unit for utilities, tents, cots, lighting, generators, and fuels. In pre-designated sites; ensures set-up according to pre-determined layout.</p> <p>Ensures setup of sanitation facilities. Obtains water for medical operations sanitation and hand wash stations. Arranges for water storage and waste water holding containers when sewer is unavailable. Arranges for removal of waste from the site, including bio-medical waste.</p> <p>Coordinates with the Services Branch/Food Unit to determine shared resource/equipment needs to supply food and water.</p>	2-4 per shift	
Supply Unit Leader/Team	<p>Coordinates medical and non-medical equipment and supply requests, and mutual aid through in coordination with the Resources Unit and Logistics Section at the DOC. Responsible for establishing a staging area, and provides location information to deployed resource teams, and vendors. Coordinates with the Resources Unit regarding requests for staffing and volunteers.</p> <p>Manages inventory of medical and non-medical supplies. Distributes supplies as requested by Operations.</p>	1 -2 per shift	
Ground Support Unit Leader/Team	<p>In pre-designated sites, uses pre-determined traffic and patient flow layout, to coordinate traffic flow at the site. At impromptu site, determines traffic and patient flow patterns with Operations.</p> <p>Requests volunteers, traffic control supplies as necessary.</p>	1 -2 per shift	
<b>Logistics Section/ Service Branch</b>			

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Communications Group Supervisor/Team	Review site communication plan and revise as necessary. Ensure all units can communicate with response partners. Maintain inventory of equipment issued. Provide radio training to new users. Request additional assistance through DOC for RACES and/or Dispatch.	1-2 per shift	
Medical Unit Leader/Team	Provides first aid and light medical treatment for <u>personnel assigned to the incident.</u>	2-3 per shift	
Food Unit Leader/Team	Coordinates with DOC to request staff and patient feeding, canteen, kitchen, or catering. Establishes water delivery (if required) for drinking purposes.	2-3 per shift	
<b>Operations Section</b>			
Triage Group Supervisor/Team	The Triage Group Supervisor and Triage Team assign and moves casualties to the appropriate Treatment Unit. Assigns infectious individuals to isolation, if an isolation area is available. Maintains the Triage Area A Registration Clerk initiates patient records. Litter bearers move patients to appropriate treatment areas. Paramedic level training is required for triage, preferably supervisor.	1-7+ per shift (EMTs)	
Treatment Group Supervisor/Team	<p>Treatment Group Supervisor and <b>Minor Treatment Team Leader, Immediate Treatment Team Leader and Delayed Treatment Team Leader and Teams.</b></p> <p>Medical personnel who provide treatment of casualties received in the Minor, Immediate and Delayed treatment areas utilizing their current certified scope of practice. Assign stabilized patients to appropriate holding areas. Paramedics and EMTs staff this group.</p> <p>Within the confines of HIPAA, the <b>Patient Inquiry Team Leader</b> provides information to family members on the location of status of casualties received within the EMS FTS. Coordinates with Transportation Recorder, Triage Registration Clerk, EMS FTS PIO, and the American Red Cross.</p>	10+ per shift (Paramedics, EMTs)	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Mental Health Group Supervisor/Team	Provides crisis counseling to casualties and stress counseling for staff. In some circumstances, may request, through the Operations Section Chief, drug and alcohol, religious practitioner staff, and preferred specialties for children with mental health conditions practitioners.	1 per shift	
Transportation Group Supervisor/Team	The Transportation Group Supervisor coordinates transportation of casualties to local hospitals, ACSs, or to out of area hospitals. Transportation Recorder initiates and maintains patient tracking records, using a triage tag that complies with EMS Authority 214, <i>Disaster Medical Systems Guidelines</i> (or an electronic system). The <b>Air Operations Controller (Team Leader)</b> manages traffic flow within the helicopter landing area, assures patient and personnel safety, heliport area maintenance, and appropriate placement of heliport markings. The <b>Ground Operations Controller (Team Leader)</b> manages traffic flow of arriving and departing ambulances and other means of ground transportation. <b>Medical Monitoring Team Leader</b> (paramedic, preferably supervisor) <b>and Teams</b> maintain patient stability while in holding areas.	Transportation Control Officer: 1 per shift, Transportation Recorder: 1 per shift, Air Operations Controller: 1 per shift, Ground Operations Controller: 1 per shift, Monitoring Team members 4 per shift ( paramedics, EMTs).	
Morgue Group Supervisor/Team	Establishes temporary morgue area Coordinates with Medical Examiner/Coroner for certifications and assistance with establishing identity if necessary. Maintains belongings of deceased individuals. Maintains chain of custody and evidence tracking records, if the incident is crime related or suspected. Instructs other Sections in evidence management.	1+ per shift.	
<b>Plans Section</b>	If required. Supervises Situation, Documentation, Resources, and Demobilization Units.	1 per shift.	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Situation Unit Leader	Coordinates with Triage, Treatment, Mental Health, Transportation, and Morgue Groups to develop status reports of the EMS FTS. Provides responses to requests for information from the DOC. Documents briefing sessions and Incident Action Planning sessions. Communicates Site Report Form to DOC.	2-4 per shift.	
Documentation Unit Leader	Prepares the EMS FTS Incident Action Plan, maintains all EMS FTS related documentation, and provides duplication services. Prepares after-action report (s).	2+ per shift.	
Resources Unit Leader	Identifies personnel needs for EMS FTS, ensuring all shifts coverage. Assigns medical and non-medical volunteers, providing orientation for new arrivals. Coordinate all EMS FTS medical and non-medical staff requests through the DOC. Ensure all EMS FTS workers are signed in, and keeping track of time.	2-4 per shift	
Demobilization Unit Leader	Assists in ensuring orderly, safe close out of EMS FTS activities. Assists to arrange transportation of EMS FTS personnel (if needed); ensures that rented equipment is returned and mutual aid resources reconciled; coordinates with the facility/site owner or operator to leave the premises in good order.	1-2	

Appendix 3: Resource Inventory

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		Notes
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	
<b>Medications</b>				
Dextrose, pre-filled syringe, 50%, 50 cc	1 case, 10/case			
Eye wash, sterile saline, bag, 1000 cc	1 each			
Furosemide ampoules, 10 mg/cc	1 box, 10/box			
Morphine sulfate, injectable, pre-filled syringe	1 box, 10/box			
Naloxone HCl, injectable, ampoules, 1 ml	1 box, 10/box			
Nitroglycerin tablets, 0.4 mg	1 bottle, 25/bottle			
Pedialyte/osmolyte solution, 8oz	1 case, 24/case			
Sterile water for irrigation, plastic bottles, 500 cc	48 each			
<b>Bandages and Dressings</b>				
Adhesive strip, 1" x 3"	1 box, 100/box			
Bandage, elastic, (Ace wrap) 2"	1 box, 12/box			
Bandage, elastic, (Ace wrap) 4"	1 box, 12/box			
Bandage, gauze, Non-Sterile, stretchable, 4" x 10 yards (Kerlix)	1 case, 96/case			
Bandage, triangular	24 each			
Burn pack, major, Ref: Dynamed #G17585	1 case, 6/case			
Burn pack, minor, Ref: Dynamed #49026	1 case, 18/case			
Compresses, gauze, bulk, sterile, 4" x 4", 2/pack	1 case, 1200 - 1500/case			
Eye shield	6 each			
Eye, pad, oval, sterile	1 box, 50/box			
Gauze, petrolatum, sterile, 5" x 9"	1 box, 50/box			
Pad, gauze, sterile, 5" x 9"	1 case, 420/case			
Tape, adhesive, waterproof, 1" x 10 yards	5 boxes, 12/box			
Tape, adhesive, waterproof, 2" x 10 yards	6 boxes, 12/box			

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		Notes
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	
Trauma dressing, 12 x 30 and approx. 3/4" thick, cotton and rayon fiber w/cellulose wadding, for use where heavy drainage is present	1 case, 50/case			
<b>Non-Disposable Medical Supplies</b>				
Backboard, straps	10 each			
Backboards, 18" x 72"	5 each			
Basin, wash, sturdy plastic, 7 quart	6 each			
Batteries, appropriate for the Mini-Mag-Lite flashlight	8 - 12 each			
Blankets, lightweight	48 each			
Bulbs, appropriate for Mini-Mag-Lite flashlight	4 each			
Gloves, work type, leather/canvas, sizes, med and large	25 pair			
Glucose test kit, w/50 pins, 50 test strips and battery, (one touch)	1 each			
Laryngoscope, multi blade set, adult, w/batteries	1 each			
Laryngoscope, multi blade set, infant/child, w/batteries	1 each			
Litters, folding, rigid poles	10 each			
Magnifying glass	1 each			
Mini-Mag-Lite flashlights	2 each			
Multi-cuff BP kit, must include thigh and infant cuffs	1 each			
Ophthalmoscope set, portable, battery powered, w/batteries	1 each			
Safety goggles	10 pair			
Sphygmomanometer, adult	6 each			
Sphygmomanometer, pediatric	3 each			
Splinter forceps	2 each			
Stethoscope	6 each			
Trauma/Paramedic scissors	12 each			

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		Notes
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	
<b>IV Sets, Needles and Syringes</b>				
Blood administration set	1 box, 48/box			
Catheter and needle, IV, 18 gauge	1 box, 50/box			
Catheter and needle, IV, 22 gauge	1 box, 50/box			
Intravenous administration set, adult	1 box, 48/box			
Intravenous administration set, pediatric	1 box, 48/box			
IV extension tubing	1 box, 48/box			
IV piggyback tubing	12 each			
Lactated ringers solution, plastic bag, 1000 cc	8 cases, 12/case			
Needle and syringe, disposable, 3 cc, 20 gauge x 1"	1 box, 100/box			
Needle and syringe, insulin 1 cc/u-100, 28 gauge x 1/2"	1 box, 100/box			
Needle, hypodermic, disposable, 20 gauge x 1-1/2"	1 box, 100/box			
Needle, hypodermic, disposable, 22 gauge x 1"	1 box, 100/box			
Sharps collector, (needle disposal)	6 each			
Sterile saline, IV solution (bags), 500 cc	50 each			
Syringe, luer lock, sterile, disposable, 5 cc	1 box, 100/box			
<b>Immobilization Supplies</b>				
Collar, extrication, hard foam, non-absorbing, adult (stores flat)	30 each			
Collar, extrication, hard foam, non-absorbing, pediatric (stores flat)	10 each			
Headbraces, cardboard	5 each			
Splint, cardboard, 12"	2 pkgs., 12/pkg.			
Splint, cardboard, 18"	2 pkgs., 12/pkg.			
Splint, cardboard, 24"	1 pkg., 12/pkg.			
Splint, cardboard, 36"	1 pkg., 12/pkg.			
Splint, traction, femur, adult	1 each			

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		Notes
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	
Splint, traction, femur, pediatric	1 each			
<b>Miscellaneous Medical Supplies</b>				
Airways, esophageal obturator	2 each			
Airways, nasopharyngeal size # 24	4 each			
Airways, nasopharyngeal size # 28	4 each			
Airways, nasopharyngeal size # 32	4 each			
Airways, oropharyngeal size # 1	6 each			
Airways, oropharyngeal size #3	6 each			
Airways, oropharyngeal size # 5	6 each			
Alcohol preps	2 boxes, 100/box			
Ambu Bag, w/adult and pediatric masks	3 each size			
Bags, plastic, 30 gallon, 8 mil	100 each			
Bedpan, fracture, plastic, disposable	6 each			
Bedpan, plastic, disposable	25 each			
Betadine scrub	1 gallon			
Blankets, disposable, plastic backing	3 cases, 40/case			
Bulb syringe, 2 oz	6 each			
Crutches, adjustable, adult	2 each			
Crutches, adjustable, child	2 each			
Diapers	1 case, 100/case			
Disposable nursing sets, including nipples, caps, rings and bottles	1 case, 36/case			
Disposable wipes	2 boxes, 40/box			
Duct tape	12 rolls			
Emesis basins, plastic	1 carton, 10/carton			
Endotracheal tubes, French 2 sizes	2 each (2 of each size)			

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		Notes
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	
Esophageal obturator airway or Combitube	2 each			
Face masks, disposable, combination use Ref: Dynamed #G17114 and #G17116	25 each			
Face masks, disposable, combination use Ref: Dynamed #G17114 and #G17116	25 each			
Facial tissues, 140 to 200 count per box	1 case, 36 - 48 boxes/case			
Feeding tube, size # 8 French	6 each			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, small	1 box, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, medium	4 boxes, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, large	1 box, 100/box			
Gloves, patient, exam, ambidextrous, nitrile, Non-Sterile, 4 mil, extra large				
Hot cups	200 ea			
Morgue pack (Disaster pouch), Ref: Dynamed #G27111	6 each			
Napkins, sanitary	48 each			
Obstetrical kits	2 each			
Suction apparatus, multi-patient use (V-vac)	2 each			
Suction catheters, French (2 sizes)	2 each (2 each Size)			
Surgical masks, with eye shield, flat	100 each			
Syringe, irrigation, 60 cc	1 box, 30/box			
Toilet paper, rolls	24 rolls			
Tongue depressors, wood	1 box 500/box			
Tourniquets, 1" width	1 pkg., 10/pkg.			
Towel set (1 ea, towel/washcloth)	48 sets			

California EMSA Recommended Supplies for FTS		Quantity per Inyo County Trailer or Barrel (# of trailers/barrels)		
Item	Qty/50 Patients	Trailers (?)	Barrels (?)	Notes
Towels, paper, rolls	1 case, 12/case			
Urinals with lids, male, disposable	1 case, 50/case			
Urinals, female, disposable	5 cases, 10/case			
Water purification tabs	1 bottle			

**Need to insert a map containing:**

- Major highways
- Main towns
- Location of trailers
- Location of barrels
- Location of ALS units
- Location of BLS units
- Location of hospitals
- Location of airports and helipads

**Anything else you think is important**

**Appendix 5:**

**FTS Forms**

**Additional useful forms may include:**

**ICS Forms, available at**

**[http://www.fema.gov/pdf/emergency/nims/ics forms 2010.pdf](http://www.fema.gov/pdf/emergency/nims/ics%20forms%202010.pdf)**

**or refer to**

**Inyo County Emergency Operations Plan**

**And**

**California Public Health and Medical  
Emergency Operations Manual (EOM)**

**Available at:**

**[www.bepreparedcalifornia.ca.gov](http://www.bepreparedcalifornia.ca.gov)**

**including:**

**Health and Medical Situation Report (SITREP) as Appendix C**

**and**

**Resource Request: Health and Medical – out of OA as Appendix D**

## FTS SITUATION REPORT FORM

**INSTRUCTIONS:** The FTS Planning Section is to complete this form at the end of each shift and fax one copy to the EOC as directed. .

<b>Date:</b>	<b>Time:</b>	<b>Site:</b>	<b>Person Reporting:</b>
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**Shift (Time Period Covered By This Report):**

<b>Phone #</b>	<b>Fax #</b>
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<b># Patients Triage:</b>	Current	Day Total	<b># Patients Minor Injury (GREEN) - Treated and Released:</b>	Current	Day Total
<b># Patients in Delayed (YELLOW):</b>	Current	Day Total	<b># Patients in Immediate (RED)</b>	Current	Day Total
<b># Patients Transported to Hospital or Other</b>	Current	Day Total	<b># Patients Deceased</b>	Current	Day Total

**Approximate # Waiting to be Triage:**

**Overall Status of Site Operations:**       No Problems to Report

- Problems With: (Describe)**
- Communications
  - Staffing
  - Security
  - Supplies
  - Public Information
  - Translation
  - Other

Resource Orders Pending:	Staffing Requirements Next Shift:
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EOC Received By:	Date:	Time:
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**FTS COMMUNICATIONS PLAN**

<b>Position</b>	<b>Telephone # or Radio Available</b>	<b>To Communicate With</b>
Communications Unit Leader		ALL
Transportation Group Supervisor		ALL
Air Operations Controller		Helicopters
Ground Operations Controller		Ambulances
Transportation Control Officer		Hospitals and/or ACSs, MHOAC
Resources Unit Leader		DOC, EOC, Hospitals, vendors, other jurisdictions, MHOAC
Site Incident Commander		PH DOC, EOC, MHOAC
Safety Officer		Law Enforcement
Public Information Officer		DOC PIO, OA EOC PIO (JIC), media
Medical Unit Leader		Hospitals, PH DOC, EOC, MHOAC
Situation Unit Leader		DOC, EOC, MHOAC
Morgue Group Supervisor		Coroner/Medical Examiner Office

<b>FTS ON-SITE TRAINING</b>					
<b>Orientation/ Training Subject</b>	<b>Command Staff</b>	<b>Support Branch</b>	<b>Service Branch</b>	<b>Operations Section</b>	<b>Plans Section</b>
EMS FTS ICS organization, chain of command, first line supervisor		All	All	All	All
Authorities for patient status change, clear for transport, or to other treatment or waiting area				All	
Safety: infection control and PPE	All		Medical Unit	All	
Safety: emergency procedures for the site	All	All	All	All	All
Contamination/Decontamination awareness				Triage and Minor Groups	
Policies for media interaction		All	All	All	All
Triage policies and procedures (basic/introductory information)	PIO	All	All	All	All
Triage refresher and in depth training				Triage Group	
Level of care and treatment to be offered	All	All	All	All	All
Other services available (Mental health, CISD, etc.)	All	All	All	All	All
Patient flow throughout EMS FTS	All	All	All	All	All
Incident Action Planning	All	All	All	All	All
Resource ordering procedures and authorities		All	All	All	All
Resource shortfalls and effects on treatment, transportation, etc.		All	All	All	All
Locations of supplies, equipment, restrooms, break areas	All	All	All	All	All
Bio-waste disposal procedures and location				All	
Operation of communication equipment	All	All	All	All	All
Food and break area; availability and timing	All	All	All	All	All
Patient rights, confidentiality	All	All	All	All	All
Evidence protection (if the incident was, or is suspected to be criminal)	All	All	All	All	All
Vulnerability of special populations with increased susceptibility				All	
Social, cultural or spiritual awareness				All	
Helicopter safety; authority to enter landing/takeoff zone; and entry limitations	All	All	All	All	All
Review of procedures and policies for deceased individuals				Morgue Group	
Reporting requirements for EMS FTS activities					Documentation Group
Debriefing, after action reporting	All	All	All	All	All

**FTS PERSONNEL TIME SHEET**

FROM DATE/TIME:			TO DATE/TIME:		SITE:		UNIT LEADER:	
#	Name (Please Print) Employee (E) Volunteer (V)	E/V	Employee Number	Assignment	Date/Time In	Date/Time Out	Signature	Total Hours
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
CERTIFYING OFFICER:					DATE/TIME SUBMITTED:			











*County of Inyo*

**HEALTH & HUMAN SERVICES DEPARTMENT**

*Behavioral Health, Public Health, Social Services, First 5, Prevention,  
and*

*Inyo Mono Area Agency on Aging*

*Drawer H, Independence, CA 93525*

*Telephone (760) 878-0247 FAX: (760) 878-0266*

*Or*

*163 May St., Bishop, CA 93514*

*Telephone (760) 873-3305 FAX: (760) 873-6505*

*JEAN TURNER, M.A., DIRECTOR*

*jturner@inyocounty.us*

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To: Inyo County Ambulance Providers

From: Jean Turner

CC: Denice Wicker-Stiles, ICEMA  
Denelle Carrington, HHS Fiscal Director  
Rick Johnson, MD, Inyo County Health Officer

Date: July 7, 2011

Re: Ambulance Rate Changes

Attached is a chart showing rate changes, effective, July 1, 2011 for Inyo County ambulance providers.

**Ambulance Rate Adjustments  
Inyo County**

<b>Ambulance Rate Components</b>	<b>Effective 7/1/2010</b>	<b>Effective 7/1/2011</b>
BLS Rate - non-emergency	\$ 497.08	\$ 546.79
BLS Rate - emergency	\$ 535.81	\$ 589.39
ALS - non-emergency	\$ 839.22	\$ 881.18
ALS - emergency	\$ 923.14	\$ 969.30
ALS II - emergency, major, medical/trauma	\$ 1,000.61	\$ 1,050.64
Ground mileage rate	\$ 22.60	\$ 23.73
Wait Time - BLS	\$ 58.11	\$ 63.92
Wait Time - ALS	\$ 83.93	\$ 88.12
Night Calls	\$ 71.02	\$ 74.57
Oxygen Cases	\$ 58.11	\$ 61.01
Disposable Oxygen Adjunct	\$ 12.91	\$ 13.56
ECG/Cardiac Monitor Cases	\$ 64.56	\$ 67.78

CPI for 2010 = 5.00%

Annual Rate Adjustment = 0.00%

Total Adjustment % = 5.00%

Total Adjustment BLS % = 10.00%

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

**Protocols Comments Compiled**

PROTOCOL #	AGENCY	COMMENT	RESPONSE
1040	Ontario Fire Department	We recently ran into some issues with an individual who had a “current” ACLS card, which he obtained from an online source, which we later found out did not meet the ICEMA requirements for re-certification. I understand that this was due to him not taking a manipulative portion. Ultimately however, he had a current ACLS card, which wasn’t valid. With many of the hospitals, and likely pre-hospital providers, moving towards online training you may want to consider clarifying that particular issue in the protocol.	We can clarify the protocol to read. <b>“CPR or ACLS cards that are obtained on line must have hands on skills evaluation with an approved American Heart or equivalent instructor.”</b>
1040 EMT-P	San Manuel Fire Department	EMT-P RE-VERIFYCATION Letter F, remove the last part “three (3) hours in each year of accreditation. The PEC agreed that field care audits can be done at any point in the 2 year accreditation cycle.	Agree with change as discussed in PEC.
3010	Ontario Fire Department	We disagree with the requirement to pay ICEMA a Training Program Approval Fee to teach the annual review class. Not only are local agencies already paying us our salary to attend the “train-the-trainer” courses, but now it appears you’re going to charge them to teach your course. By having instructors qualified to teach your annual review throughout the county it would seem it takes the burden off of you to have to provide regular training for it. The fee is inappropriate.	No change. Historically we have waived the fee however have left it on the fee schedule.
3010 EMT-P	San Manuel Fire Department	Under PROCEDURE #3, Change the wording for clarity, <u>Failure to take two different ARC's during your two year accreditation period will result in the EMT-P or MICN.....</u>	Agree will make the change.

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
5030	Ontario Fire Department	<p>The intent to implement policy changes without specific review from the public or specific committees is unacceptable. The language “but are not limited to” appears to open the door for changes which may be far more meaningful than simply changing typographical or formatting errors. “Time critical protocols or policies,” is also subjective. The language should be removed.</p> <p>Additionally, language needs to be introduced to structure protocol release on a bi-annually or semi-annual basis. Sporadic implementation, or multiple policy changes throughout the year, leads to confusion among the providers, creates difficulty in scheduling training, and will ultimately lead to policy errors and QI issues.</p>	<p>No change These will be primarily clerical changes any significant changes will continue through the normal channels.</p>
5030	Redlands Community	#2 Policy changes may occur without specific review from the public or specific committees. Changes include (the list). Eliminate the sentence “but not limited to”.	No change
5030	Upland FD	p.1: change “policy changes may occur without specific review...” to “policy changes may <b>not</b> occur without specific review...” <b>OR</b> “changes include, but are limited to:...” The time critical protocols or policies (the last bullet point) needs to be removed. This situation would fall under “Emergency Protocols/Policies.”	No change
Controlled sub. 7020	Upland FD	p.2: change “All wastage of unused portions of controlled substances ...” to “All wasted portions of controlled substances...”	Agree will change
8030 EMT-P	San Manuel Fire Department	<p>Under TRANSPORT</p> <p>#4 Remove the second part of the sentence. By the nature of our trauma system it is highly unlikely that there will be more than 20 minute difference between our Pediatric and Burn centers.</p>	#4 Change to: Pediatric burn patients identified as a CTP should always be transported to the closest trauma center with or without Burn capabilities. When there is less than

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>#5 Delete the reference to EMS aircraft. It is redundant to policy 14054.</p> <p>#6, Add the word unmanageable. Change to: Burn patients with (unmanageable) respiratory compromise.....</p>	<p>20 minutes difference in transport time, a pediatric trauma center is the preferred destination.</p> <p>No change to #5</p> <p>No change to #6</p>
10060 EMT-P	San Manuel Fire Department	<p>FIELD ASSESSMENT INDICATORS</p> <p>#7 awkward sentence, change to: In blunt chest trauma consider bilateral tension pneumothorax.....</p>	Agree will change
10110 EMT-P	San Manuel Fire Department	<p>Under PROCEDURES IN SYMPTOMATIC BRADYCARDIA,</p> <p>#6 at the end of the sentence add: with signs of adequate tissue perfusion. This makes the statement consistent with #7.</p>	Agree will change
11040	Mammoth Hospital	<p>Heart rate less than 50</p> <p>Base contact after Atropine unsuccessful</p> <p>Dopamine at 2-10 mcg/kg/min</p>	<p>Change Heart rate to 50.</p> <p>No other changes</p>
11050	Mammoth Hospital	<p>Adenosine for SVT only if regular and monomorphic</p> <p>Consider Procainamide for stable wide complex SVT (not suspected WPW – this is too complicated)</p>	No change - American Heart language.
11050 EMT-P	San Manuel Fire Department	<p>Under NARROW COMPLEX SUPRAVENTRICULAR TACHYCARDIA (spelling)</p> <p>Change 4<sup>th</sup> bullet from enefective to ineffective.</p>	Agree will change
11060	Mammoth Hospital	<p>Please add exception for Inyo/Mono Counties:</p> <p>In Inyo/Mono Counties the assigned base station should be contacted for STEMI consultation.</p>	Agree will change
11060	Upland FD	<p>p.2: #5. Avoid abbreviation of MS, replace with morphine sulfate</p>	Agree will change

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
11070	Mammoth Hospital	ALS interventions # 5—can there be consistency with the wording for ETCO2 capabilities? For example, needle cric protocol states for agencies with waveform capnography document the shape of the wave and the capnography number in mmHG. Mono County also prints out the ETCO2 strips of the waveform and number for liability reasons.	Agree will make consistent
11070	Mammoth Hospital	Initiate CPR beginning with compressions Consider establishing and advanced airway Dopamine 2-10 mcg/kg/min	No change American Heart language.
11090 EMT-P	San Manuel Fire Department	Under ALS INTERVENTIONS 7 <sup>th</sup> bullet, change respiration to respiratory, to read: For B/P >90mm/Hg with no respiratory difficulties and adequate signs of tissue perfusion:	Agree will change



# 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:** Virginia Hastings  
ICEMA Executive Director

Reza Vaezazizi, MD  
ICEMA Medical Director

**SUBJECT: PROTOCOL PUBLIC COMMENT PERIOD**

The following attached twenty-two (22) protocols have been reviewed and revised by the Protocol Education Committee and the Medical Advisory Committee (MAC) and are now available for public comment and recommendations. The public comment period has been shortened due to a recommendation by the Medical Advisory Committee (MAC) to enable presentation of recommended protocols and comments to the Emergency Medical Care Committees (EMCC) in July to prevent further delay in implementation of the protocols. Many of these protocols reflect the updated American Heart Association changes and directly impact patient care.

ICEMA encourages all system participants to submit 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).

Protocol Reference #:

- Draft Controlled Substance Policy
- 1040 Requirements for EMT-P Accreditation
- 1060 Certification/Accreditation Review Policy
- 3010 Annual Review Class (ARC)
- 5030 Procedure for Adoption of Protocols and Policies
- 6030 AED Service Provider Policy – Public Safety
- 6040 Lay Rescuer AED Implementation Guidelines
- 8030 Burn Destination and Criteria Policy
- 8060 San Bernardino County Requests for Hospital Diversion Policy
- 8080 Bed Delay Patient Destination Policy
- 9110 Treatment of Patients with Airborne Infections and Transport Recommendations
- 10060 Needle Thoracostomy
- 10070 Needle Cricothyrotomy

- 10110 Transcutaneous Cardiac Pacing
- 10120 Synchronized Cardioversion
- 10130 Automatic External Defibrillation (AED)-BLS
- 11020 Airway Obstruction – Adult
- 11040 Bradycardias – Adult
- 11050 Tachycardias – Adult
- 11060 Suspected Acute MI
- 11070 Cardiac Arrest – Adult
- 11090 Shock (Non-Traumatic)

VH/RV/DWS/SS/mae



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## **CONTROLLED SUBSTANCE POLICY**

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### **PURPOSE**

To establish minimum requirements and accountability for ICEMA approved ALS providers to procure, stock, transport, and use controlled substances in compliance with the Federal Controlled Substances Act.

### **POLICY**

All ICEMA approved ALS providers shall have a formal agreement with a qualified Medical Director or a drug authorizing physician who agrees to purchase controlled substances using the appropriate DEA registration number and forms. This physician will retain ownership, accountability and responsibility for these controlled substances at all times. All ALS providers will develop policies compliant with Title 2, chapter 13 of the Federal Controlled Substance Act. The policies must clearly outline the procedure for procurement, receipt, distribution, waste management and associated record keeping for the controlled substances purchased under their DEA registration number.

The medical director or drug authorizing physician must be a physician licensed to practice medicine in State of California and must apply and obtain a valid DEA registration number for the ALS provider they propose to purchase controlled substances for. If a physician has agreements with multiple ALS providers, separate DEA registration numbers are required for each individual provider agency. Physicians should not use their personal DEA registration number that they use for their clinical practice.

### **PROCEDURE**

All controlled substances will:

- Be purchased and stored in tamper evident containers.
- Be stored in a secure and accountable manner.
- Be kept under a “double lock” system at all times.
- Be counted a minimum of daily or at any change of shift or change in personnel.

Required documentation:

- ALS providers must maintain a log of all purchased controlled substances for a period of no less than 2 years.
- All controlled substance usage will be documented in patient care records.

- All wastage of unused portions of controlled substances must be witnessed and documented by at least two licensed providers (both providers must sign the log).
- In the event of breakage of a narcotic container an incident report will be completed and the damage reported to the appropriate supervisor.
- Discrepancies in the narcotic count will be reported immediately to the appropriate supervisor and a written report must be submitted.







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## REQUIREMENTS FOR EMT-P ACCREDITATION

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### PURPOSE

To define the accreditation requirements for an eligible individual to practice as an Emergency Medical Technician-Paramedic (EMT-P) within the counties of Inyo, Mono and San Bernardino.

### AUTHORITY

Title 22, Division 9, Chapter 4, Section 100164 of the California Health and Safety Code.

### PROCEDURE

#### Initial EMT-P Accreditation

1. Possess a current State Paramedic License.
2. Submit the appropriate ICEMA application with:
  - a. ICEMA Fee. The fee is not refundable or transferable.
  - b. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization in the ICEMA region.
  - c. Copy of front and back of current State [EMT-P License](#).
  - d. [Copy of current government issued photo identification.](#)
  - e. [A signed copy \(front and back\) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.](#)
  - f. [A signed copy \(front and back\) of the individual's current Advanced Cardiac Life Support Card.](#)
  - d. ~~Copy of front and back of current signed BLS/CPR and ACLS cards.~~
  - e-g. ~~Copy of course completion certificate.~~

3. Photo taken by ICEMA when application is submitted. If the application is submitted by mail, the applicant must provide a photo which is full face and passport compliant. Photocopy of the applicant's driver's license must be included for verification purposes.
- ~~3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.~~
4. A provisional card ~~may~~will be issued upon receipt of items #1 through #3. The provisional EMT-P may function using the approved State Basic Scope of Practice while working with a partner who is fully accredited as an EMT-P within the local EMS region for thirty (30) calendar days from receipt of completed application. The ICEMA Medical Director may extend this provisional status for just cause.
5. If the accreditation requirements are not completed within thirty (30) days, the applicant must complete a new application and pay a new fee to begin another thirty (30) day period. An applicant may only apply for initial accreditation a maximum of three (3) times per calendar year.
6. ~~C~~Successfully complete an orientation (not to exceed eight (8) classroom hours) of local protocols and policies given by an ICEMA approved EMT-P orientation/skills instructor and document training in all ICEMA approved optional~~undefined~~ scope of practice areas. The ICEMA Medical Director may waive this requirement for EMT-P accreditation applicants/graduates from who graduate from an approved EMT-P training institution in the ICEMA ~~this~~ region.
7. ~~P~~Successfully pass the local accreditation written examination with a minimum score of eighty percent (80%)~~skills testing in undefined scope of practice~~.
  - a. A candidate who fails to pass the ICEMA accreditation exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
  - b. A candidate who fails to pass the ICEMA accreditation~~written~~ exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in ~~relation to~~ ICEMA protocols, policies / procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a score of 85%.
  - c. If the candidate fails to pass the ICEMA accreditation exam on the third attempt, the candidate **will be ineligible for accreditation for a period of six (6) months at which time candidate must reapply and successfully complete all initial accreditation requirements.**

8. Successfully complete a supervised field evaluation to consist of no less than five (5) but no more than ten (10) ALS responses. The ICEMA Medical Director may waive this requirement for EMT-P accreditation applicants who graduate from an approved EMT-P training institution in the ICEMA region who have met **all** of the following conditions:
  - a. Course completion was within six (6) months of the date of application for accreditation.
  - ~~a.~~b. Field internship was obtained within the ICEMA region with an ICEMA approved EMT-P preceptor.
  - ~~b.~~c. Complete and sign the waiver documenting items (a) and (b). No other form will be accepted.
9. The Medical Director shall evaluate any candidate who fails to successfully complete the field evaluation and may recommend further evaluation or training as required. Failure to complete the supervised field evaluation may constitute failure of the entire process.
10. ~~ICEMA~~The local EMS agency will notify individuals applying for accreditation of the decision to accredit within ~~fifteen~~thirty (30) days of receipt of completed application.

### **EMT-P Reverification**

1. Possess a renewed California EMT-P license and current ICEMA accreditation. If ICEMA accreditation has lapsed for more than one (1) year, the individual must comply with the initial accreditation procedure.
2. Photo taken by ICEMA when Reverification form is submitted. If the form is submitted by mail, the applicant must provide a photo which is full face and passport compliant. Photocopy of the applicant's driver's license must be included for verification purposes.  
~~Photo taken at ICEMA when Reverification form is submitted. A driver's license size photo (no tinted glasses or hats) may be submitted with the Reverification form~~
3. Submit the ICEMA Continuous Accreditation Reverification form with:
  - a. ICEMA fee. The fee is not refundable or transferable

- b. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization by ICEMA.
- c. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
- d. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
- e. Documentation of two (2) ICEMA approved Skills Day, one (1) during each year of accreditation, a minimum of six (6) months apart.
- f. Documentation of six (6) hours of field care audits obtained within the ICEMA region, three (3) hours during each year of accreditation.

**Effective January 1, 2014, failure to meet items (e) and (f) above will result in penalties as outlined in ICEMA Protocol Reference #5090- ICEMA Fee Schedule and still complete the requirements prior to reverification.**

- h. Documentation of two (2) ~~consecutive~~different ICEMA Annual Review classes (ARC), -one during each year of accreditation.  
~~(NOTE: This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)~~

NOTE: Individuals accredited less than six (6) months must submit a new application and a current state license.

Individuals accredited more than six (6) months but less than one (1) year must submit a new application, items a-d above and complete one half of each educational requirement.

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

**Accreditation exam does not replace or fulfill the requirement for Skills Days or Field Care Audits. These must be completed prior to reverification.**

- 4. Individuals without documentation of two (2) ~~consecutive~~different ARC classes must pay testing fee and penalties as set by ICEMA and ~~successfully~~pass the ICEMA accreditation exam with a score of eighty percent (80%).

5. A candidate who fails to pass the ICEMA accreditation exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a passing score of 85%.
6. An individual who fails to pass the ICEMA accreditation exam on the second attempt will have to pay the ICEMA approved fee and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies and/ procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a passing score of 85%.
7. If the candidate fails to pass the ICEMA accreditation exam on the third attempt, the candidate **will be ineligible for accreditation for a period of six (6) months at which time candidate must reapply and successfully complete all initial accreditation requirements.**



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## CERTIFICATION/ACCREDITATION REVIEW POLICY

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### PURPOSE

To establish a process for the disciplinary review of certification and/or accreditation held by all levels of prehospital care personnel within the ICEMA region.

### AUTHORITY

California Health and Safety Code 1798.200-, 1798.208

California Code of Regulations, Title 22, Division 9, Chapter 6

California Government Code Title 2, Chapter 5, Section 11507.6-11507.7, 11513, 11514

### POLICY

1. Disciplinary proceedings are in accordance with Title 22, Chapter 6 of the California Code of Regulations at <http://www.emsa.ca.gov/legislation/division25.rtf>.
2. Paramedic licensure actions (e.g., immediate suspension) shall be performed according to the California Health and Safety Code 1798.202.
3. Notification to the EMS Authority is through the Form EMSA-Negative Action Report at [http://www.emsa.ca.gov/emt1-p/negative\\_action\\_personnel.doc](http://www.emsa.ca.gov/emt1-p/negative_action_personnel.doc).
4. If the action is to recommend to the EMS Authority for disciplinary action of an EMT-P license:
  - a. A summary explaining the actions of the EMT-P that are a threat to the public health and safety pursuant to Section 1798.200 of the Health and Safety Code; and,
  - b. Documented evidence, relative to the recommendation, collected by the Medical Director, forwarded to the State EMS Authority.
5. Request for discovery, petitions to compel discovery, evidence and affidavits shall be followed pursuant to the Administrative Procedures Act (Government Code, Title 2, Chapter 5, Sections 11507.6, 11507.7, 11513, and 11514). <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=11001-12000&file=11500-1154>.



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## ANNUAL REVIEW CLASS (ARC)

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### PURPOSE

To define the eligibility and procedural requirements for the mandatory yearly Annual Review Class (ARC) for the Paramedic (EMT-P) applying for Continuous Accreditation and/or the Mobile Intensive Care Nurse (MICN) applying for Continuous Certification or Inactive MICN status within the ICEMA Region. The Annual Review Class is developed by a multidisciplinary task-force and the curriculum approved by the ICEMA Medical Director.

### PROCEDURE

1. The authorized class is valid from January 1 through December 31 of each year. ~~This protocol will apply to those individuals with expiration dates after Jan 31, 2007.~~
2. It is the responsibility of the individual to take the class during each year of accreditation or certification.
3. Failure to take an Annual Review Class during each year of accreditation or certification will result in the EMT-P or MICN having to successfully pass the ICEMA EMT-P Accreditation/MICN Certification Written Exam with a minimum score of eighty percent (80%). Additionally, financial penalties will apply.
4. The EMT-P or MICN must register and pay the exam fee to ICEMA prior to the scheduled deadline.

### CRITERIA FOR TEACHING THE ANNUAL REVIEW CLASS

1. Approved C.E. providers shall request approval from ICEMA to provide the class:
  - a. Submit a completed application to be approved as a training program.
  - b. Application must include a list of your proposed trainers with copies of their resumes attached.
  - c. Pay the ICEMA approved Training Program approval fee.
  - d. Approval is granted for a period of one (1) year.

2. ICEMA should be notified thirty (30) days in advance of the class offering in order to be able to post the class dates, times and locations on the ICEMA website and newsletter.
3. Within fifteen (15) days of class completion, the provider will send the original C.E. roster to ICEMA with the Instructor Evaluation and any other material requested. All other course materials and records will be maintained, for a period of four (4) years, by the approved training program per Protocol Reference #3020, Policy for CE Provider Requirements.
4. Continuing Education hours will be granted for the class **with**in accordance to Protocol Reference #3020 Continuing Education Provider Requirements.



## PROCEDURE FOR ADOPTION OF PROTOCOLS AND POLICIES

### PURPOSE

To establish ~~minimum procedural requirements~~ procedures for the adoption, amendment or repeal of ICEMA medical control protocols ~~and~~, policies and procedures.

Constituency advice and review is an essential component of policy, procedure and protocol development.

~~The provisions of this policy shall not apply to any protocol and/or policy not required to be approved by stipulation outlined in the Joint Powers Agreement.~~

The EMS constituent review process is advisory to ICEMA for the formulation of prehospital care policies and procedures. Policy/procedure suggestions and/or draft policies are accepted from committees, system participants, individuals and/or interested parties.

### POLICY

1. ICEMA will review all protocols on a bi-annual basis or as necessary to ensure time critical policy changes.
2. Automatic policy changes may occur without specific review from the public or specific committees. Automatic changes include, but are not limited to:
  - changes in wording to clarify the objective
  - changes in the listed order for clarity or better flow
  - changes to assure protocol or policy continuity
  - changes required to comply with state and local law and/or regulation to maintain public health and safety.
  - correction of typographical or formatting errors
  - ~~determination that changes are needed to a protocol or policy that were not initially foreseen in its development.~~
  - time critical protocols or policies
3. ICEMA staff shall develop an initial draft with input from appropriate external

- agencies, organizations or other established advisory committees (i.e TSAC, STEMI, Stroke) as subject matter dictates, and present proposed protocols to the Protocol Education Committee (PEC) for review.
4. The PEC will provide additional input and make recommendations to ICEMA.
  5. Following review by appropriate committees, draft protocols will be submitted to the Medical Advisory Committee (MAC).
  6. Following MAC review, protocols will be released for public comment period.
  7. ICEMA shall consider all relevant matter presented to it before accepting, amending or repealing any protocol or policy.
  8. Policies will be released for thirty (30) day public comment period. The public comment period may be shortened to 15 days if ICEMA determines the policy or protocol to be time sensitive.
  9. Upon closure of the public comment period ICEMA will prepare a final draft policies/procedures with a detailed spreadsheet for presentation at the Emergency Medical Care Committee (EMCC) meetings held in all three counties. Spreadsheet shall include all comments received and ICEMA's response to the comments.
  10. Following endorsement by the EMCCs, policies will be presented to the ICEMA Medical Director and ICEMA Executive Director for signature.
  11. Protocols and/or policies approved by the Medical Director and Executive Director shall become effective no sooner than thirty (30) days after the date of approval.

#### **EMERGENCY PROTOCOLS/POLICIES ADOPTION OR REPEAL PROCESS**

1. If ICEMA determines that an emergency protocol or policy the adoption or repeal of a protocol and/or policy is necessary for the immediate preservation of the public health and safety or general welfare, a the protocol and/or policy may be adopted, amended, deleted or repealed as an emergency action of appeal.
2. Any finding of an emergency shall will include a written statement describing the specific facts showing the need for immediate action. The statement and the protocol or policy shall be immediately forwarded to the ICEMA Medical Control Advisory Committee and appropriate EMS provider agencies. The emergency protocol and/or policy will become effective no sooner than five (5) days following dissemination to the ICEMA Medical Control Advisory Committee.

3. ~~No protocols or policyies adopted under the emergency adoption provision shall remain in effect for approximately more than one hundred and twenty (120) days to allow for appropriate committee review and public comment period, unless ICEMA complies with the other provisions of this policy.~~
4. ~~A protocol or policy adopted under this emergency provision shall not be readopted as an emergency protocol or policy except with the express prior approval of the Health Officer of San Bernardino County.~~
5. ~~Protocols and/or policies approved by the Medical Director and the Health Officers shall become effective no sooner than 30 days after the date of approval by the Medical Director.~~

**PUBLIC COMMENT PERIOD NOTICE OF PROPOSED ACTION — PUBLICATION, MAILING, EFFECTIVE PERIOD**

ICEMA will:

1. Open all protocols to public comment for a period of thirty (30) days except in instances where the Executive Director and ICEMA Medical Director deem it necessary to shorten the period to protect and/or improve public health and safety.
2. a. Post proposed changes on the ~~ublished in the~~ ICEMA website at www.ICEMA.net/newsletter.
3. b. E-mMailed ~~\_~~ proposed changes to voting members of the Emergency Medical Care Committees.  
ICEMA Medical Control Advisory Committee.
4. . E-mail proposed changes ~~Mailed~~ to each EMS provider agency, ~~whom ICEMA believes to be interested in the proposed action.~~
5. d. ME-mail proposed changes ~~ailed t~~o every person whom has filed a request for notificationee thereof with ICEMA.
6. ICEMA shall mMake copies of the proposed protocols and/or policies available to the public and ~~constituentsunty agencies at a nominal cost~~ which is consistent with a policy of encouraging the widest possible notice distribution to interested persons.
5. Any oversight in notification described above

~~6.7.~~ 3. — ~~The failure to mail notice to any person as provided in this policy~~ shall not invalidate any action taken by ICEMA pursuant to this policy.

**CONTENTS OF NOTICE OF PROPOSED PUBLIC COMMENT PERIOD NOTIFICATION ADOPTION, AMENDMENT OR REPEAL**

1. The notice of proposed adoption, amendment, or repeal of a protocol or policy shall include:

a. A statement of the time and place of proceedings for adoption, amendment, or ~~repeal~~ of a protocol or policy.

b. ~~The name and telephone number of the agency contact person to whom inquiries concerning the proposed action may be directed.~~

c. A date by which comments submitted ~~in writing~~ must be received in writing ~~to present statements, arguments, or contentions in writing relating to the proposed action~~ in order for them to be considered by ICEMA before it adopts, amends, or repeals a protocol or policy.

~~a.~~ —

b.d. The provisions of this section shall not be construed in any manner ~~which results to in the~~ invalidation ~~of~~ a protocol or policy due to perceived ~~because of the alleged~~ inadequacy of the notice content if there has been substantial compliance with this requirement.

~~4.~~ —

~~2.~~ — ~~The provisions of this section shall not be construed in any manner which results in the invalidation of a protocol or policy because of the alleged inadequacy of the notice content if there has been substantial compliance with this requirement.~~

**CONDITIONS ON SUBSTANTIAL CHANGES OR MODIFICATIONS**

~~On the date and at the time and place designated in the notice, ICEMA shall afford any interested person or his duly authorized representative, or both, the opportunity to present statements, arguments, or contentions in writing, with opportunity to present the same orally at the ICEMA Medical Control Advisory Committee Meeting. ICEMA shall consider all relevant matter presented to it before adopting, amending or repealing any protocol or policy.~~

~~2. ICEMA shall have authority to continue or postpone the ICEMA Medical Control Advisory Committee Meeting from time to time to such time and at such place as it shall determine.~~

**PETITION REQUEST FOR ADOPTION, AMENDMENT OR REPEAL OF PROTOCOL CONTENTS**





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## AED SERVICE PROVIDER POLICY – PUBLIC SAFETY

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### PURPOSE

To establish a standard mechanism for designation and approval of Public Safety AED Service Providers in the ICEMA region. Public Safety Personnel is defined as Firefighter, Peace Officer and/or Lifeguard.

### AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9, Chapter 1.5 First Aid Standards for Public Safety Personnel.

### POLICY

AED Public Safety service providers shall be approved by ICEMA prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

### PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit an application for a specialty program with the ~~the~~ following information to ICEMA for review and approval:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications.
5. Identify the training program to be used.
6. Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
7. Procedures for maintenance of the AED.

8. Policies and procedures to collect maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.
9. Identify the Medical Director.

### **RECORD KEEPING AND REPORTING REQUIREMENTS**

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

1. ~~The total number of patients defibrillated who were discharged from the hospital alive~~
2. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known.
3. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest.
4. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
5. A listing of all public safety AED authorized personnel



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## LAY RESCUER AED IMPLEMENTATION GUIDELINES

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### PURPOSE

This is a guidance document to assist businesses and organizations implement Lay Rescuer automated external defibrillator programs within the ICEMA region. Using automated external defibrillators (AED) for out-of-hospital cardiac arrests has been proven to increase survival rates. ICEMA supports the use of Lay Rescuer (non-licensed or non-certified personnel person) access AEDs within the ICEMA region, and these guidelines are intended to facilitate the proliferation of AED programs.

### AUTHORITY

1. California Health and Safety Code Sections 1797.5, 1797.107, 1797.190 and 1797.196.
2. California Code of Regulations Title 22, Division 9, Chapter 1.8 Sections 100031 through 100040, as revised January 8, 2009. (See Attachment C).

### REQUIREMENTS OF BUSINESS/ORGANIZATION/INDIVIDUAL

1. Become familiar and comply with California AED regulations and statutes, referenced above.
2. Complete a Notification of Defibrillator Site form (Attachment A) listing each AED unit being deployed in the ICEMA region. Submit the form to:

ICEMA  
515 N. Arrowhead Ave.  
San Bernardino, CA 92415-0060

3. Re-submit a Notification of Defibrillator Site form if any of the information becomes outdated (i.e., the AED is moved to a different location, a new AED is purchased, etc.).
4. Every time an AED is used, complete the Report of Defibrillator Use form (Attachment B), and submit via fax to ICEMA at (909) 388-5825, within 24 hours of use.

**IMPLEMENTATION CHECKLIST**

Listed below are key elements taken from the California AED regulations and statutes. Each element must be satisfied to implement a Lay Rescuer AED programs within the ICEMA region.

<input type="checkbox"/>	Notify ICEMA of the existence, location, and type of every AED within the ICEMA region. The business or organization responsible for the device must, at the time the device is acquired and placed, notify ICEMA. (Attachment A).
<input type="checkbox"/>	Expected AED users/rescuers must complete a training course in cardiopulmonary resuscitation (CPR) and in use of the AED device. The training curriculum must comply with regulations adopted by the California Emergency Medical Services Authority, the standards of the American Heart Association, or the American Red Cross. The training shall include a written and skills examination.
<input type="checkbox"/>	Any AED training course for non-licensed or non-certified personnel (Lay Rescuers) shall have a physician medical director
<input type="checkbox"/>	A California licensed physician and/or surgeon must be involved in developing an internal emergency response plan for the site of the AED. The physician/surgeon is responsible for ensuring the businesses or organization's AED program complies with State regulations and requirements for training, notification, and maintenance. The internal emergency response plan shall include, but not be limited to, the provisions for immediate notification of 911 and AED-trained on-site personnel, upon discovery of the emergency. As well as procedures to be followed in the event of an emergency that may involve the use of an AED
<input type="checkbox"/>	The business/organization/lay rescuer in possession of the AED must comply with all regulations governing the training, use, and placement of the device.
<input type="checkbox"/>	The AED must be maintained and regularly tested according to the manufacturer's operation and maintenance guidelines, the American Red Cross, and American Heart Association. Maintenance and testing must also comply with any applicable rules and regulations set forth by the US Food and Drug Administration and any other applicable authority.
<input type="checkbox"/>	The AED must be checked for readiness at least once every 30 days and after each use. Records of these periodic checks shall be maintained by the business/organization in possession of the device.
<input type="checkbox"/>	A mechanism shall exist to ensure that any person rendering emergency care or using the AED activate the emergency medical services system (911) immediately. Further, the business/ organization in possession of the AED is responsible for reporting any use of the AED to the physician medical director and to ICEMA. (Attachment B).
<input type="checkbox"/>	A mechanism shall exist that assures the continued competency of the expected AED users/ rescuers employed by the business/organization in possession of the AED. Such mechanism shall include periodic training and skills proficiency demonstrations sufficient to maintain competency.
<input type="checkbox"/>	For every AED unit acquired up to five units, no less than one employee per AED unit shall complete a training course in CPR and AED. After the first five AED units are acquired, for each additional five AED units acquired, one additional employee shall be trained beginning with the first additional AED unit acquired. The business/organization in possession of the AED shall have trained employees available to respond to a cardiac emergency during normal operating hours.

**ATTACHMENT A****Notification of Defibrillator Site**

<b>Physician Medical Director Information</b>	
Physician's Name CA Medical License No:	
Physician's Phone No:	
I am serving as the Physician Medical Director for this defibrillation program as described in the California Code of Regulations, Section 100039. I hereby certify that the AED program described herein complies with all applicable laws and regulations, including placement, use, training, and maintenance of the device(s).	
Date:	Signature:
<b>On-Site Contact Information</b>	
Name of On-Site Contact:	
Employer:	
Phone Number of On-Site Contact:	
Physical Address of On-Site Contact:	
Mailing Address of On-Site Contact:	

<b>AED Location Information</b>	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
<b>Equipment Information</b>	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

<b>AED Location Information</b>	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
<b>Equipment Information</b>	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

<b>AED Location Information</b>	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
<b>Equipment Information</b>	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

<b>AED Location Information</b>	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
<b>Equipment Information</b>	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

**ATTACHMENT B**

**Notification of Defibrillator Site**

Name Of AED Service Provider:	
Date of Occurrence:	
Time of Occurrence:	
Place of Occurrence: (Address & specific location)	
Patient's Name:	
Patient's Age:	
Patient's Sex:	
Approximate down time prior to your arrival:	
Did anyone witness the collapse/arrest?	
Alert Time (time you were notified):	
Was CPR used prior to AED at victim?	
Time of first shock (if given):	
Total number of shocks:	
Did victim regain a pulse at scene?	
Responder Name(s):	
Name and phone number of person completing form:	

***Additional Comments Information:***

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***FAX this completed report to ICEMA within 24 hours of use of an AED.***

***FAX to: 909-388-5825***



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## BURN DESTINATION AND CRITERIA POLICY

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### PURPOSE

To ensure the appropriate destination of patients sustaining burn injuries.

### AUTHORITY

Health and Safety Code Sections 1797.220, 1797.222 & 1798  
California Code of Regulations, Title 22, Division 9, Sections 100144, 100304, 100107, 100128, 100175A2

### DEFINITIONS

Adult Patients: a person appearing to be  $\geq$  15 years of age.

Pediatric Patients: a person appearing to be  $<$  15 years of age.

Burn Patients: patients meeting ICEMA's burn classifications, minor, moderate or major.

Critical Trauma Patients (CTP): patients meeting ICEMA's Critical Trauma Patient Criteria.

Trauma Hospital: a licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws and regulations.

### POLICY

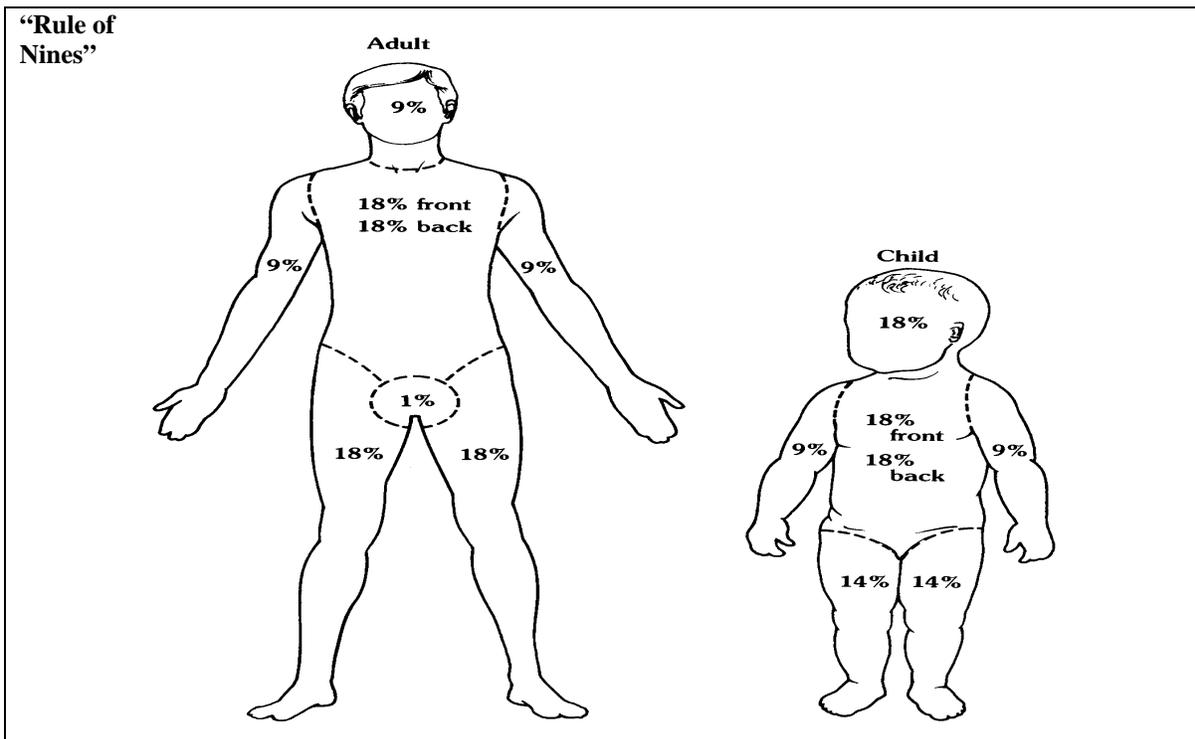
#### A. TRANSPORTATION

1. Burn patients meeting minor or moderate classifications will be transported to the closest **most appropriate** receiving hospital.
2. Burn patients meeting major burn classification will be transported to the closest most appropriate burn center (in San Bernardino County contact ARMC).
3. Burn patients meeting the physiologic or anatomic criteria for CTP will be transported to the most appropriate trauma hospital, Refer to Protocol #15030, Trauma Triage Criteria and Destination Policy.

4. Pediatric burn patients identified as a CTP will be transported to a pediatric trauma hospital when there is less than a twenty (20) minute difference in transport time to the pediatric trauma hospital versus the closest trauma hospital.
5. When estimated transport to the most appropriate trauma hospital (for patients identified as a CTP) is thirty (30) minutes or less, ground ambulance shall be the primary means of transport. EMS Aircraft transport shall not be used unless ground transport is expected to be greater than thirty (30) minutes and EMS Aircraft transport is expected to be significantly more expeditious than ground transport. If an EMS aircraft is dispatched, adherence to the Aircraft Destination Policy #14054 (in San Bernardino County) is mandatory.
6. Burn patients with respiratory compromise, or potential for such, will be transported to the closest ~~most appropriate~~ receiving hospital for airway stabilization.
7. Hospital trauma diversion status: Refer to Protocol #8060 San Bernardino County Hospital Diversion Policy.
8. Paramedics may contact the base hospitalstation or trauma base hospitalstation for destination consultation on any patient that does not meet any of the above criteria, but who, in the paramedic's opinion, would be more appropriately serviced by direct transport to a burn center.

**B. 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 <del>MOST</del> 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 <del>MOST</del> 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                             <ul style="list-style-type: none"> <li>• Any significant burn to face, eyes, ears, genitalia, or joints</li> </ul> </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                             <ul style="list-style-type: none"> <li>• Any significant burn to face, eyes, ears, genitalia, or joints</li> </ul> </li> </ul>	<p><b>CLOSEST <del>MOST</del> APPROPRIATE BURN CENTER</b></p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>



**C. EXCEPTIONS**

The burn patient who presents with the following:

<p><b>Airway Stabilization:</b></p> <p><u>Transport to the closest—most appropriate receiving hospital for airway stabilization when the patient:</u></p>	<ul style="list-style-type: none"> <li>• has respiratory compromise, or potential for compromise</li> </ul>
<p><b>Transport to the closest most appropriate receiving hospital when the patient:</b></p>	<ul style="list-style-type: none"> <li>• has deteriorating vital signs</li> <li>• is pulseless and apneic</li> </ul>
<p><b>EMS Aircraft Indications:</b></p> <p><u>An EMS aircraft may be dispatched for the following events:</u></p>	<ul style="list-style-type: none"> <li>• MCI</li> <li>• Prolonged extrication time (&gt; twenty (20) minutes)</li> <li>• <b>Do Not Delay Patient Transport</b> waiting for an enroute EMS aircraft</li> </ul>
<p><b>EMS Aircraft Transport Contraindications:</b></p> <p><u>The following are contraindications for EMS aircraft patient transportation:</u></p>	<ul style="list-style-type: none"> <li>• Patients contaminated with Hazardous Material who cannot be decontaminated and who pose a risk to the safe operations of the EMS aircraft and crew</li> <li>• Violent patients with psychiatric behavioral problems and uncooperative patients under the influence of alcohol and/or mind altering substances who may interfere with the safe operations of an EMS aircraft during flight</li> <li>• Stable patients</li> </ul>

	<ul style="list-style-type: none"> <li>• Ground transport is &lt; 30 minutes</li> <li>• Traumatic cardiac arrest</li> <li>• Other safety conditions as determined by pilot and/or crew</li> </ul>
<b>Remote Locations:</b>	<ul style="list-style-type: none"> <li>• Remote locations may be exempted from specific criteria upon written permission from the EMS Medical Director</li> </ul>

**D. CONSIDERATIONS**

1. Scene time should be limited to ten (10) minutes under normal circumstances.
2. 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 hospitalstation contact shall be made.

**E. RADIO CONTACT**

1. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.
2. For patients meeting Trauma Triage Criteria (Physiologic, Anatomic, Mechanism of Injury, and/or Age and Co-Morbid Factors), a trauma base hospitalstation shall be contacted in the event of patient refusal of assessment, care, and/or transportation.
4. In Inyo and Mono Counties, the assigned base hospitalstation should be contacted for CTP consultation.



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## SAN BERNARDINO COUNTY REQUESTS FOR HOSPITAL DIVERSION POLICY

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### **PURPOSE**

To define policy and procedures for hospitals to request temporary diversion of Advanced Life Support (ALS) Ambulances.

### **AUTHORITY**

Health and Safety Code, Division 2.5, Chapter 6, Section 1798(a), 1798.2, 1798.102; California Code of Regulations (CCR), Title 22, Division 9, Chapter 4, 100169.

### **PRINCIPLES**

- A request for diversion of Advanced Life Support (ALS) ambulances should be a temporary measure.
- Final authority relating to destination of ALS ambulances rests with the base hospital physician.
- The approved EMS system diversion policy applies to the 9-1-1 emergency system and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.
- A hospital's request to divert in the approved categories shall be made by the emergency department attending physician or by the trauma surgeon for trauma hospital diversion, in consultation with the hospital CEO or delegated responsible administrative representative. The consultation with the administrative officer must be documented and available for review.
- Hospitals must maintain a hospital diversion policy that conforms to the ICEMA Diversion Protocol. The policy should include plans to educate all appropriate staff on proper utilization of diversion categories, internal procedures for authorizing diversion and procedures for notification of system participants.
- ICEMA may perform unannounced site visits to hospitals on temporary diversion status to ensure compliance with the ICEMA Diversion Policy.
- ICEMA may randomly audit base hospital records to ensure diverted patients are transported to the appropriate destination.

- When possible, ICEMA staff will contact the hospital to determine the reasons for internal disaster diversion.
- ICEMA reserves the right and responsibility to advise any hospital that the diversion is not appropriate for a 9-1-1 system and may remove the hospital from diversion through the Reddinet.

## **POLICY**

A request for diversion of ALS ambulances may be made for the following approved categories:

### **1. Neuro/CT Diversion:**

#### **(DOES NOT APPLY FOR TRAUMA CENTERS FOR TRAUMA DIVERSION)**

The hospital's CT scanner is not functioning and, therefore, is not the ideal destination for the following types of patients:

- New onset of altered level of consciousness for traumatic or medical reasons.
- Suspected stroke

### **2. Trauma Hospital Diversion (*for use by designated trauma hospitals only*):**

The general surgeon for the trauma service and other designated trauma team resources are fully committed and are NOT immediately available for incoming patients meeting approved trauma triage criteria.

- The request for trauma diversion should only be applicable if the general surgeon and back-up general surgeon are committed. The ability to request trauma hospital diversion cannot be used in cases of temporary unavailability of subspecialists.
- **WHEN ALL DESIGNATED TRAUMA HOSPITALS ARE ON TRAUMA DIVERSION, TRAUMA CENTERS SHALL ACCEPT ALL TRAUMA PATIENTS.**

**Designated trauma hospitals may not divert patients meeting trauma triage criteria to a non-designated hospital except in instances of Internal Disaster Diversion.**

### **3. Internal Disaster Diversion:**

Requests for Internal Disaster Diversion shall apply only to physical plant breakdown threatening the emergency department or significant patient services.

*Examples of internal disaster diversion include bomb threats, explosions, power outage and a nonfunctional generator, fire, earthquake damage, hazardous materials exposure, incidents involving the safety and/or security of a facility.*

**INTERNAL DISASTER DIVERSION SHALL NOT BE USED FOR STAFFING ISSUES**

- Internal Disaster Diversion shall stop all 9-1-1 transports into the facility.
- The hospital CEO or AOD shall be notified and that notification shall be documented in the Reddinet.
- If the hospital is also a designated base hospital, the hospital should consider immediately transfer of responsibility for on-line control to another base hospital based upon prearranged written agreement and notification to the 9-1-1 provider.
- Internal disaster diversion status shall be entered immediately into the Reddinet.
- If capability exists, hospital shall notify all primary 9-1-1 dispatching agencies.
- Within 72 hours, hospital shall advise ICEMA and the State Department of Health Services in writing (e-mail is acceptable) of the reasons for internal disaster and how the problem was corrected. The written notification shall be signed by the CEO or delegated responsible individual.

**EXCEPTIONS TO NEURO AND TRAUMA DIVERSION ONLY:**

- Basic Life Support (BLS) ambulances shall not be diverted.
- Ambulances on hospital property shall not be diverted.
- Patients exhibiting unmanageable problems, e.g., unmanageable airway, uncontrolled hemorrhage, cardiopulmonary arrest, in the field shall be transported to the closest emergency department regardless of diversion status.



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## BED DELAY PATIENT DESTINATION POLICY (San Bernardino County High Desert Area Only)

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### PURPOSE

A responsibility of an EMS agency is to assure that emergency patients requesting emergency medical care through the 9-1-1 system receive assistance and transport as quickly as possible. This is accomplished in part by requiring response time standards for all 9-1-1 providers, public and private sectors. Bed delay is threatening timely responses to such calls in the High Desert.

ICEMA protocol currently allows 9-1-1 responders to consider patient request when such request will not take the ambulance out of the service area for an extended period of time and when the condition of the patient allows transport to other than the closest appropriate emergency department.

This policy is to ensure timely responses to 9-1-1 calls and sets forth destination policies for transport to St. Mary Medical Center, Victor Valley Community Hospital and Desert Valley Hospital when the 9-1-1 response system falls below a system status level that delays timely responses to 9-1-1 calls.

### AUTHORITY

Health & Safety Code, Division 2.5, Chapter 4, Local EMS Agency, Section 1797.220 and Chapter 5, Medical Control, Section 1798.

### DEFINITIONS

**Bed Delay:** Ambulance units are determined to be on bed delay if the patient has not been removed from the ambulance gurney within twenty-five (25) minutes of arrival at hospital as documented in the ePCR.

**High Desert:** Exclusive Operation Areas 12, 17, 25 and 16 (excluding area south of intersection Highway 138 and Highway 2 and Wrightwood).

**Deployed Ambulance Units:** The number of ambulances assigned to provide service within a specific geographic area. This may vary based on provider's deployment plan.

**System Status Level:** The number of **available** ambulance units in a specific geographic area.

## POLICY

1. When forty percent (40%), or higher, of deployed ambulance units in a specific High Desert area (excluding Barstow) are on bed delay with system status level 4 or below, or committed to other 9-1-1 calls, as determined by the dispatch center, transport providers in the High Desert area shall follow the destination policy below:
  - a. Patients shall be transported to the hospital whose emergency department has the least number of ambulances on bed delay as determined by the agency's dispatch center.
  - b. Transporting agencies may not have patients sign "Against Medical Advice" (AMA) forms as a tool to supersede this destination policy. Patients that refuse transport to the suggested facility may sign the AMA form if they choose to self transport.
  - c. Transporting units are not required to honor patient requests when this emergency protocol is implemented.
  - d. When this emergency protocol is implemented, transporters shall note the following on the patient care record:

### **"EMERGENCY BED DELAY DESTINATION PROTOCOL"**

2. The following exceptions apply to the destination policy noted in No. 1:
  - a. Patient **meets trauma center destination criteria** ("*Trauma Triage Criteria and Destination*" Reference #15030).
  - b. Patient meets STEMI center destination criteria ("*STEMI Receiving Center Policy*", Reference #6070).
  - c. Base station direction to other facility.
  - d. Cardiac arrest or unstable patients will be transported to the closest receiving hospital regardless of bed delay.
3. When advised by dispatchers that No. 1 above is not applicable, patient requests may be honored in accordance with "*Patient Refusal of Care or Other Patient Request*", Reference #9100.

4. ICEMA will review all patient care records where destination is determined based on this policy. If a provider does not submit patient care records utilizing the ePCR, the provider must submit a copy of the patient care record to ICEMA within seventy-two (72) hours.



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## TREATMENT OF PATIENTS WITH AIRBORNE INFECTIONS AND TRANSPORT RECOMMENDATIONS

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### **PURPOSE**

To establish a policy for transportation of patients with suspected or known airborne infections within the ICEMA region.

### **AUTHORITY**

California Code of Regulations, Title 8, §5199. Aerosol Transmissible Diseases.

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

#### **Signs and Symptoms (may include)**

1. Fever > 100°F (37.8 C).
2. Runny nose, cough, sore throat (or any combination).
3. May or may not have gastrointestinal symptoms.

### **PROCEDURE**

#### **Patient Care**

1. Treatment for a symptomatic individual who is a confirmed case or a suspected case of infectious disease is supportive based upon assessment findings.
2. IV fluids and appropriate medications are to be initiated per established protocols.
3. Exacerbation of underlying medical conditions in patients should be considered, thoroughly assessed and treated per established protocols.

#### **Infection Control of Ill Persons During Treatment and Transport**

1. EMS personnel should incorporate rapid assessment of potential infectious environment into their scene survey/safety and maintain an index of suspicion for infectious disease when a patient with signs/symptoms consistent with the case definition(s) is encountered.
2. Personal Protective Equipment (PPE) must be immediately accessible and employed by all EMS providers who come into close contact with ill and/or

- infectious patients as outlined in the California ATD Standard. This would include the driver in vehicles with open driving compartments particularly when the patient is receiving aerosolized treatment.
3. All required care should be provided to the patient(s) as indicated by protocol(s).
  4. Patients with suspected or confirmed case-status should be transported as warranted by assessment findings. All patients in acute respiratory distress will be transported. If transport is initiated, symptomatic patients should not be transported with non-symptomatic patients. The patient should be accompanied by a single attendant during transport to limit exposure unless patient treatment needs dictate otherwise.
  5. After thorough assessment and attention to the patient's respiratory status, the patient should be encouraged to wear a surgical mask if it can be tolerated or oxygen mask if indicated. Close monitoring of the patient's respiratory status is required at all times during treatment and transport.

### **Specific EMS Personal Protective Equipment Standards and Transport Recommendations**

1. For EMS personnel treating and/or transporting a patient that meets the case definition of infectious respiratory disease, protection must include wearing a fit-tested N95 respirator (or higher), disposable gloves and eye protection (face shield or goggles).
2. The ambulance ventilation system should be operated in the nonrecirculating mode, and the maximum amount of outdoor air should be provided to facilitate dilution. If the vehicle has a rear exhaust fan, use this fan during transport. If the vehicle is equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle, use this unit to increase the number of Air Changes per Hour (ACH). Air should flow from the cab (front of vehicle), over the patient, and out the rear exhaust fan. If an ambulance is not used, the ventilation system for the vehicle should bring in as much outdoor air as possible, and the system should be set to nonrecirculating. If possible, physically isolate the cab from the rest of the vehicle, and place the patient in the rear seat.<sup>1</sup>
3. Clean hands thoroughly with soap and water or an alcohol-based hand gel before and after all patient contacts.
4. All equipment and surface areas should be thoroughly decontaminated with an anti-bacterial cleaner following each patient contact.

<sup>1</sup> Centers for Disease Control, *MMWR* December 30, 2005 / 54(RR17);1-141



## NEEDLE THORACOSTOMY

### FIELD ASSESSMENT/TREATMENT INDICATORS

Signs and symptoms of tension pneumothorax may include any or all of the following:

1. Increasing agitation.
2. Progressively worsening dyspnea/cyanosis.
3. Decreased or diminished breath sounds on the affected side.
4. Hypotension.
5. Distended neck veins.
6. Tracheal deviation away from the affected side.
7. Consider in blunt trauma to chest the possibility of bilateral tension pneumothorax if SPO2 remains low with a patent airway or with poor respiratory compliance.

### PROCEDURE

1. Explain the procedure to the patient:
  - a. If conscious, place the patient in an upright position if able to tolerate.
  - b. If patient is unconscious or in axial-spinal immobilization, leave supine.
2. Use an approved pre-packaged device. If unable to obtain an approved pre-packaged device utilize the following:
  - a. For patients weighing more than 50kg - 14 or 16 gauge, 2 to 3 1/2 inch needle and cannula.
  - b. For patients weighing less than 50kg - 18g, 1 to 1 1/4 inch needle and cannula.
3. Prepare the area with antiseptic wipes -- second intercostal space, midclavicular line. An alternative needle thoracostomy site may include the fourth or fifth intercostal space, mid-axillary line at nipple level. Caution should be exercised in the later stages of pregnancy

when a higher (3rd) intercostal space should be used to avoid injury to the liver or spleen.

4. Insert needle perpendicular to the chest wall at the level of the superior border of the third rib until pleura is penetrated as indicated by one or more of the following:
  - a. A rush of air.
  - b. Ability to aspirate free air into the syringe.
5. Remove syringe and needle stylet and leave cannula in place with. ~~Add~~ flutter valve.
6. Secure needle hub in place with tape or other approved device.
7. Reassess patient lung sounds and respiratory status immediately and every five (5) minutes thereafter.
- ~~8. An alternative needle thoracostomy site may include the fourth or fifth intercostal space, mid axillary line at nipple level. Caution should be exercised in the later stages of pregnancy when a higher (3<sup>rd</sup>) intercostal space should be used to avoid injury to the liver or spleen.~~
9. Contact Base Station with patient update.



## NEEDLE CRICOTHYROTOMY

### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Upper airway obstruction with severe respiratory distress.
2. When unable to ventilate utilizing conventional airway maneuvers or devices.

### ABSOLUTE CONTRAINDICATION

~~Patients less than two (2) years of age.~~  
~~Transection of the distal trachea~~

### PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts. Use in-line cervical stabilization as needed. Explain procedure to a conscious patient.
2. Assemble appropriate equipment and pre-oxygenate prior to attempting procedure.
  - a. Locate the soft cricothyroid membrane between the thyroid and cricoid cartilage.
  - b. Insert appropriately sized needle and verify position. (An approved needle cricothyroid device may be utilized per manufacture's guidelines.)
    - i. Adult 10-15 gauge needle.
    - ii. Pediatric 12-15 gauge needle.
  - c. Per manufacturer's recommendation, attach cannula adapter to BVM or use Translaryngeal Jet Ventilation (TLJV) device and ventilate with either BVM or TLJV (one (1) second on and three (3) seconds off).
  - d. Assist with exhalation by intermittently pressing downward and upward on chest wall if needed. Consider adding a 3-way stopcock or y-connector inline to facilitate exhalation.
3. Document verification of needle placement.
4. Monitor end-tidal CO<sub>2</sub> and/or pulse oximetry and chest expansion. [For agencies](#)

with waveform capnography document the shape of the wave and the capnography number in mmHG

5. Contact Base Station if unable to adequately ventilate patient and transport immediately to closest hospital for airway management.

~~5.6.~~

## **DOCUMENTATION**

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



## TRANSCUTANEOUS CARDIAC PACING

### FIELD ASSESSMENT/TREATMENT INDICATORS

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

### PROCEDURE IN SYMPTOMATIC BRADYCARDIA

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

### PROCEDURE IN ASYSTOLE

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

resuscitative efforts.

## **DOCUMENTATION**

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



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## SYNCHRONIZED CARIOVERSION

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### FIELD ASSESSMENT/TREATMENT INDICATORS

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

### PROCEDURE

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

- b. Charge unit to 200 - 360 joules, or clinically equivalent biphasic energy level per manufacture guidelines.
  - c. Defibrillate per the appropriate corresponding protocol.
9. Document all reassessments of rhythm and pulses.



## AUTOMATIC EXTERNAL DEFIBRILLATION (AED) - BLS

### 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, ~~apneic and pulseless~~ pulseless and apneic (~~agonal respirations of less than six (6) per minute~~ "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, ~~for two (2) minutes if time from arrest is over five (5) minutes.~~
2. Power on the AED.
- ~~2.3.~~ 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. (For children between one (1) and nine (9) years of age, pediatric pads are to be used according to manufacturers' guidelines, if available. If not using pediatric pads, follow all manufacturers' guidelines for use on the pediatric patient).
- ~~3.4.~~ Check-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, ~~apneic and pulseless~~pulseless and apneic, continue CPR for two (2) minutes and ~~reassess~~reanalyze.
- 4.5. Continue care as indicated by patient condition until ALS providers assume care or patient starts to move.
- 5.6. 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 ~~2005-2010~~2010 AHA Guidelines for CPR and Emergency Cardiac Care standards for defibrillation for adults and pediatrics no later than ~~June 30, 2007~~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.



## 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~~ (if the rescuer is unable to encircle the victim's abdomen or the patient is in the late stages of pregnancy, utilize chest thrusts)~~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. Begin immediate CPR at a 30:2 ratio for two (2) minutes.~~
3. ~~If apneic, attempt two (2) ventilations with bag valve mask. If no chest rise, reposition airway and reattempt. Each time the airway is opened to ventilate, look for an object in the victim's mouth and if found, remove it.~~
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.~~

~~6.5.~~ If available, place AED per Protocol Reference #10130.

### **ALS INTERVENTION – UNRESPONSIVE**

1. If apneic and able to ventilate, establish advanced airway.
2. If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
3. If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy per Protocol Reference #10070.



## BRADYCARDIAS - ADULT

### ASYMPTOMATIC STABLE BRADYCARDIA

#### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Heart rate less than 60 bpm.
2. Signs of adequate tissue perfusion.

#### BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

#### ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider bolus of 300cc NS, may repeat.
2. 2. Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital. If possible, obtain a 12-lead EKG to better define the rhythm.
- 2.3. Monitor and observe for change in patient condition.

### SYMPTOMATIC UNSTABLE BRADYCARDIA

#### FIELD ASSESSMENT/TREATMENT INDICATORS

Signs of inadequate tissue perfusion/shock, ALOC, or ischemic chest discomfort.

#### BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.

3. Administer oxygen as clinically indicated.

### ALS INTERVENTIONS

~~1. Consider advanced airway, as indicated.~~

~~2.1. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation.~~

~~3.2. Place on Cardiac monitor and obtain rhythm strip for documentation. If possible, obtain a 12-lead EKG to better define the rhythm. Provide copy to receiving hospital.~~

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

5. If Atropine is ineffective or Consider TCP, per Protocol Reference #10110, instead of Atropine for documented MI, 3<sup>rd</sup> degree AV Block with wide complex and 2<sup>nd</sup> degree Type II AV Block, utilize Transcutaneous Cardiac Pacing, per Protocol Reference #10110.

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

~~7.6. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P greater than 90mmHg, and for signs of inadequate tissue perfusion/shock.~~

~~8.7. Contact Base Station if interventions are unsuccessful.~~



## TACHYCARDIAS - ADULT

### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Signs and symptoms of poor perfusion.
2. Heart rate greater than 150 bpm.

### BLS INTERVENTIONS

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

### ALS INTERVENTIONS

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

### Narrow Complex Supraventricular Tachycardia (SVT)

- Initiate NS bolus of 300ml IV.
- Valsalva/vagal maneuvers
- Adenosine 6mg rapid IV push, followed by 20ml NS rapid infusion. If no conversion, may repeat twice at 12mg followed by 20ml NS rapid infusion.
- If adenosine is eneffective, —Cconsider Verapamil 5mg slow IV over three (3) minutes. May repeat every 15 minutes to a total dose of 20mg.
- Consider Procainamide 20mg/min IV for suspected Wolf-Parkinsons White; may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by more than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.
- Synchronized cardioversion; refer to Protocol Reference #10120.

- Contact Base Station.

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

1. Consider Adenosine administration if the rate is regular and the QRS is monomorphic. Adenosine is contraindicated for unstable rhythms or if the rhythm is an irregular or polymorphic wide complex tachycardia.

~~1.2.~~ Procainamide 20mg/min IV; may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by more than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.

~~2.3.~~ If Procainamide administration is contraindicated or fails to convert the rhythm, consider Lidocaine 1mg/kg slow IV. May repeat at 0.5mg/kg every ten (10) minutes until maximum dose of 3mg/kg given and initiate infusion of 2mg/min.

4. Polymorphic VT should receive immediate unsynchronized cardioversion (defibrillation). Consider infusing Magnesium 2gms in 100ml of NS over five (5) minutes if prolonged QT is observed during sinus rhythm post-cardioversion.

~~3.~~ Magnesium 2gms in 100ml NS infuse over five (5) minutes for Torsades de Pointe.

~~4.~~ Consider Adenosine administration if arrhythmia is suspected to be of supraventricular origin.

5. Precordial thump for witnessed spontaneous Ventricular Tachycardia, if defibrillator is not immediately available for use.

6. Synchronized cardioversion; refer to Protocol Reference #10120.

~~7.~~ If arrhythmia suppressed, or cardioversion unsuccessful, administer Lidocaine 1mg/kg slow IV. May repeat at 0.5mg/kg every ten (10) minutes until maximum dose of 3mg/kg is given, then initiate infusion at 2mg/min.

~~—~~ Contact Base Station.

### Atrial Fib/Flutter

1. Transport to appropriate facility.

~~If condition deteriorates, proceed to the following interventions:~~

~~2.~~ If condition deterioratesFor patients who are hemodynamically unstable, proceed to Synchronized cardioversion; refer to Protocol- Reference #10120.

~~If symptoms have been present for greater than forty eight (48) hours, electric or pharmacologic cardioversion should not be attempted unless the patient is unstable.~~

~~2.3. Contact Base Station.~~

- ~~a. Synchronized cardioversion; refer to Protocol Reference #10120.~~
- ~~b. For Narrow Complex rhythms only, give Verapamil 5mg slow IV over three (3) minutes. May repeat in fifteen (15) minutes at 10mg slow IV over three (3) minutes.~~
- ~~c. Procainamide 20mg/min IV. May repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by greater than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.~~
- ~~d. Contact Base Station.~~



## SUSPECTED ACUTE MI

### 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.
- ~~4. History of heart disease.~~
- ~~5. Angina.~~

### 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, ~~if trained.~~
5. May assist patient with self-administration of Nitroglycerin and/or Aspirin.

### ALS INTERVENTIONS

- ~~1. Obtain rhythm strip for documentation.~~
- ~~2.1. Aspirin 162mg.~~
- ~~3.2. Consider early vascular access.~~
- ~~4.3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300ml NS bolus, may repeat.~~
- ~~5.4. 12 Lead Technology :~~
  - ~~a. If patient condition is critical, peri-arrest, do not delay transport to obtain ECG.~~

- b.a. Obtain 12 Lead ECG. Do not disconnect 12-lead cables until necessary for transport.
- e.b. If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, ~~consider obtaining~~ obtain a right-~~chest~~sided 12 Lead (V4R).
- d.c. If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with Base Station or receiving hospital in rural areas is recommended. (Nitrates ~~should be avoided~~ are contraindicated in the presence of ~~suspected~~ RVI or hypotension).
- e.d. With documented ST segment elevation in two (2) or more contiguous leads, contact Base Station for destination decision while preparing patient for expeditious transport. Reference Protocol #6070, Cardiovascular Stemi Receiving Centers.
- f.e. Repeat 12 Lead at regular intervals, but do not delay transport of patient. If patient is placed on a different cardiac monitor for transport, transporting provider should obtain an initial 12-lead on their cardiac monitor and leave 12-lead cables in place throughout transport.
- 6.5. Nitroglycerin 0.4mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. ~~Consider Morphine Sulfate for pain management when N~~ Nitroglycerin is contraindicated if there are (signs of inadequate tissue perfusion or if recent use of sexual enhancement medications have been utilized within the past forty-eight [48] hours). Utilize MS for pain control when Nitroglycerin is contraindicated.
- 7.6. Morphine Sulfate 2mg IV, may repeat every three (3) minutes to total 10mg. Consider concurrent administration of Nitroglycerin with Morphine Sulfate if there is no pain relief from the initial Nitroglycerin administration. Contact Base Station for further Morphine Sulfate orders.
- 8.7. Consider establishing a saline lock ~~enroute on same side as initial IV~~ as a secondary IV site.
9. ~~Complete thrombolytic checklist, if time permits.~~
8. ~~Contact Base Station for further Morphine Sulfate orders~~ Make early STEMI notification to the receiving STEMI center.
10. \_\_\_\_\_

~~11.9.~~ In Radio Communication Failure (RCF) may give up to an additional 10mg Morphine Sulfate in 2mg increments with signs of adequate tissue perfusion.



## CARDIAC ARREST - ADULT

### FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

### BLS INTERVENTIONS

1. Assess patient, ~~maintain appropriate airway and~~ begin CPR according to current AHA Guidelines, and, maintain appropriate airway
  - a. Compression rate shall be 100/minute utilizing 30:2 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
  - a.b. Ventilation rate shall NOT exceed 12/min. Ventilatory volumes shall be the minimum necessary to cause sufficient to cause adequate chest rise.
  - b.c. Compression rate shall be 100/minute utilize 30:2 compression to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
2. If available, place AED and follow Protocol Reference #10130. CPR is **not** to be interrupted except briefly for rhythm assessment.

### ALS INTERVENTIONS

1. Initiate CPR for two (2) minutes if no CPR was performed prior to arrival and down time is greater than five (5) minutes while applying the cardiac monitor.
2. Determine cardiac rhythm and proceed to appropriate intervention defibrillate if indicated. Begin a two minute cycle of CPR.
- 2.3. Obtain IV/IO access.
4. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100/min-per-minute without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.

5. Utilize continuous quantitative waveform capnography, if available, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC.

3. \_\_\_\_\_

4. \_\_\_\_\_

### **Ventricular Fibrillation/Pulseless Ventricular Tachycardia**

1. Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use ~~200 joules~~maximum available.
2. Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.
3. Administer Epinephrine 1.0mg IV/IO during each two (2) minute cycle of CPR after ~~each~~every defibrillation unless capnography indicates possible ROSC.
4. Reassess rhythm ~~;~~ after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as above.
5. After two (2) cycles of CPR, consider ~~administering~~ Lidocaine 1.5mg/kg IV/IO. May repeat at 0.75mg/kg every five (5) minutes to maximum dose of 3.0mg/kg.
6. If patient remains in pulseless VF/VT after five cycles of CPR, consult base station.

### **Pulseless Electrical Activity (PEA) or Asystole**

1. Assess for reversible causes and initiate treatment.
2. Continue CPR with evaluation of rhythm every two (2) minutes.
3. Administer fluid bolus of 300ml NS IV, may repeat.
4. Administer Epinephrine 1.0mg IV/IO during each two (2) minute cycle of CPR after each rhythm evaluation.
5. ~~Consider administration of Atropine 1.0mg IV/IO after second two (2) minute cycle of CPR. May repeat twice for a total of 3.0mg~~
6. ~~Consider termination of efforts if patient remains in PEA <60, asystole (confirm in two leads), or other agonal rhythm after successful intubation and initial medications without a reversible cause identified.~~

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

1. ~~Insert NG/OG Tube to relieve gastric distension per Protocol Reference #10080, Insertion of NG/OG Tube. Obtain blood glucose, if indicated; administer Dextrose 50% 25gms IV.~~
2. ~~Obtain blood glucose. If indicated, administer Dextrose 50% 25gms IV. Insert NG/OG Tube to relieve gastric distension per Protocol Reference #10080, Insertion of NG/OG Tube.~~
3. Naloxone 2.0mg IV/IO/IM for suspected opiate overdose.

**Termination of Efforts in the Prehospital Setting**

1. The decision to terminate efforts in the field should take into consideration, first, the safety of personnel on scene, and then family and cultural considerations.
- ~~1.2. Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:~~
  - ~~a. No shocks were delivered~~
  - ~~b. No ROSC after a minimum of ten (10) minutes of ACLS~~
3. Base station contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the PCR for documentation purposes.

~~Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:~~

- ~~Arrest was not witnessed~~
- ~~Adequate bystander CPR was not provided~~
- ~~No shocks were delivered~~
- ~~No ROSC after a minimum of ten (10) minutes of ACLS~~

**NOTE**

1. If ROSC is achieved, obtain a 12-lead EKG.

2. Utilize continuous waveform capnography, if available, to identify loss of circulation.
- ~~1.3.~~ For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine infusion of 400mg in 250ml of NS may be initiated at 5-~~20~~1010 mcg/kg/min IV to maintain signs of adequate tissue perfusion.
- ~~2.~~ May initiate Lidocaine infusion of 2mg/min with documented conversion from VT/VF.
- ~~3.4.~~ Base station physician may order additional medications or interventions as indicated by patient condition.
- ~~4.~~ Base station contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the PCR for documentation purposes.



## SHOCK (NON-TRAUMATIC)

### PRIORITIES

1. ~~ABC's.~~
2. ~~Identify signs of shock.~~
3. ~~Determine need for fluid replacement.~~
4. ~~Consider early transport.~~

### FIELD ASSESSMENT/TREATMENT INDICATORS

1. Patient exhibits signs/symptoms of shock.
2. Determine mechanism of illness.
3. History of GI bleeding, vomiting, diarrhea.
4. Consider hypoglycemia or narcotic overdose.
5. ~~Hypothermia preventative measures.~~

### ~~ALS INTERVENTIONS~~PARAMEDIC SUPPORT PRIOR TO BASE STATION CONTACT

1. ~~Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O2 saturation on room air or on home O2 if possible.~~
2. ~~Oxygen therapy as clinically indicated. Obtain oxygen saturation on room air, unless detrimental to patient condition. Be prepared to support ventilations with appropriate airway adjuncts.~~
3. ~~Place on cardiac monitor.~~
4. ~~Place in trendelenburg if tolerated.~~
5. ~~Obtain vascular access.~~

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6. If hypotensive or has signs or symptoms of inadequate tissue perfusion give fluid challenges:

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- a. In the adult give 500ml IV bolus, may repeat once to sustain a B/P>90mmHg or until tissue perfusion improves.
- b. In the pediatric patient give 20ml/kg IV bolus, may repeat once for tachycardia, change in central/peripheral pulses, limb temperature transition, altered level of consciousness.

7. For B/P>90mmHg and no respiration difficulties and adequate signs of tissue perfusion:

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- a. In adults, maintain IV rate at 150ml/hour.
- b. In pediatric patients, maintain IV at TKO.

#### **BASE STATION MAY ORDER**

- \*1. Establish 2<sup>nd</sup> large bore IV enroute.**
- \*2. Dopamine infusion at 5-20mcg/kg/min if hypotension persists despite fluid administration.**

*\*May be done during radio communication failure.*

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

**A-EMT Protocols Comments**

PROTOCOL #	AGENCY	COMMENT	RESPONSE
7010 AEMT	San Manuel Fire	Under Limited ALS Standard Drug and Equipment list, Delete the reference to Narcotics in the first paragraph. Under Non-Exchange Airway/Suction Equipment, Change "Manual powered suction device" to Portable suction device. Add the following: End Title CO2 device – Pediatric and Adult (may be integrated into bag) 1 of each for transport and non-transport units.	Further Discussion
9010 AEMT	San Manuel Fire	Spelling Under patient contact, change "patent" to patient. Under "Limited ALS Interventions #3, change the line "augment BLS treatment with advanced treatments as indicated or available." TO, Integrate BLS and LALS treatments as clinically indicated.	Accept
13020 AEMT	San Manuel Fire	Limited ALS Interventions, #4 References AEMT prorocol14060. There is no protocol #14060 in the AEMT package? This could be a reference to EMT-P protocol 14060? If so add "when assisting an EMT-P".	Accept
15010 AEMT	San Manuel Fire	Page 2, Under "Isolated Head Injury" Delete the bullet "Insert nasogastric/orogastric tube".  Under Traumatic Arrest Delete reference to Monitor V-Fib or V-Tach and defibrillate as per ACLS guidelines. Consider changing to "Apply AED and follow AED mfg. guidelines."	Accept
9020 AEMT	San Manuel Fire	Under PROCEDURE, change EMT-P to AEMT.	Accept
10010 AEMT	San Manuel Fire	Add the use of End Title CO2 device – Pediatric and Adult. This should be added to the Standard Drug and equipment list also. Also add the use of capnography if it is available on scene.	Accept

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
10010 AEMT and 10020 AEMT	San Manuel Fire	Under PROCEDURE, Either remove the numbers and use bullet points, OR Place #5 Pre-Oxygenate in the #1 place. AEMT has no devices using airway circuits. To reflect this in #12 change, "attach the breathing circuit" to Attach the BVM and End Title C02 device to the King LT.	Further Discussion
10160 AEMT	San Manuel Fire	Remove #4, OR change to: all neonatal and pediatric patients with a KING LT airway".	Further Discussion
11100 AEMT	San Manuel Fire	Page 3 Under Respiratory distress: Remove "Place advanced airway if the patient presents facial/oral swelling or if respiratory depression develops due to inhalation injury." In inhalation burns The King LT may add to the edema in the oropharynx and its use should be discouraged. Consider changing to "Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP."	Further Discussion
13013 AEMT	San Manuel Fire	Under LIMITED ALS INTERVENTIONS #1, CHANGE "Advanced airway as clinically indicated" to, Airway interventions as clinically indicated.	Accept



# Inland Counties Emergency Medical Agency

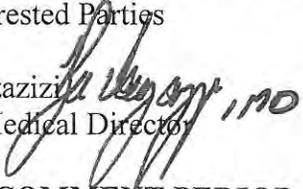
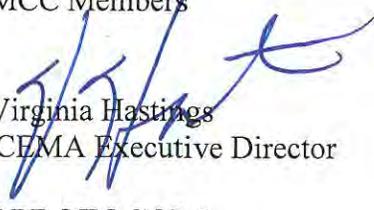
*Serving San Bernardino, Inyo, and Mono Counties*

*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:** 1-800-340-5411M-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.



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## **AIRWAY OBSTRUCTION - ADULT**

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### **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

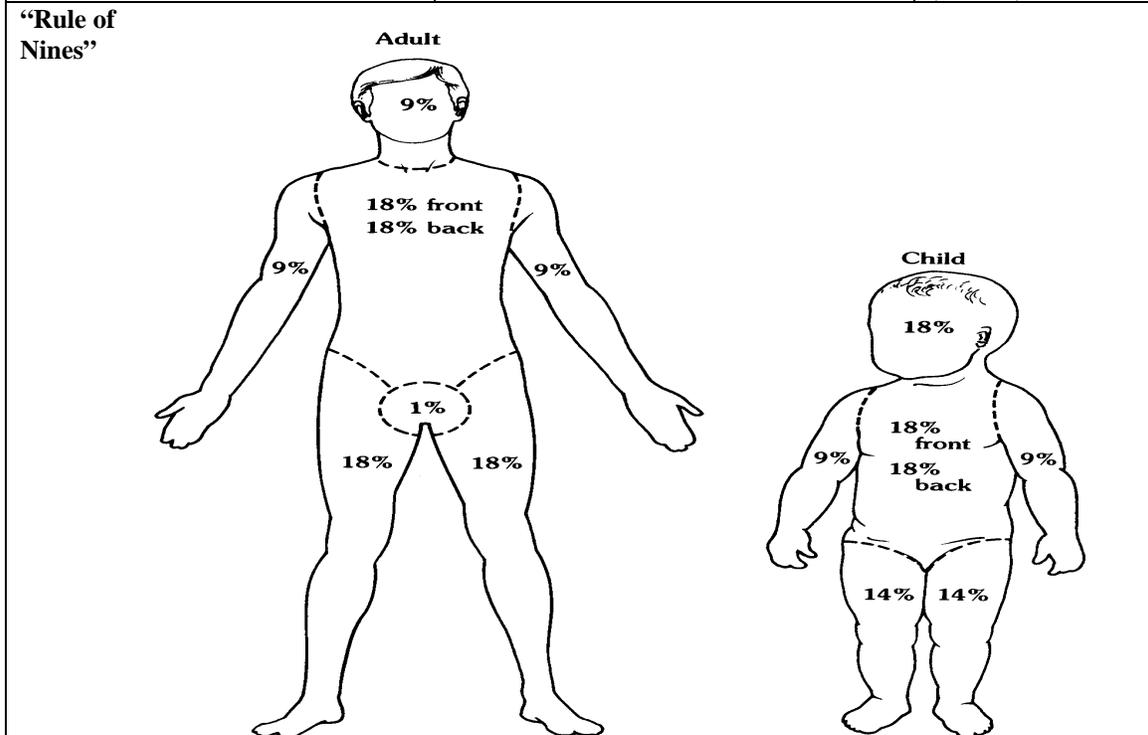
BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> <li>• Assess environment and extrication as indicated</li> <li>• Break contact with causative agent (stop the burning process)</li> <li>• Ensure patient airway, protecting cervical spine as indicated</li> <li>• Remove clothing 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.       <ul style="list-style-type: none"> <li>○ IV NS 250ml boluses, may repeat to a maximum of 1000ml.</li> </ul> </p> <p><i>Stable:</i>        BP&gt;90mmHG and/or signs of adequate tissue perfusion.       <ul style="list-style-type: none"> <li>○ IV NS 500ml/hour</li> </ul> </p>

<u>BLS Continued</u>	<u>Limited ALS Continued</u>
<p><b>MANAGE SPECIAL CONSIDERATIONS:</b></p> <p><b>Thermal Burns:</b> Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.</p> <p><b>Chemical Burns:</b> Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.</p> <p><b>Tar Burns:</b> Cool with water, do not remove tar.</p> <p><b>Electrical Burns:</b> Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.</p>	<ul style="list-style-type: none"><li>• Transport to appropriate facility: <i>Minor Burn Classification:</i> transport to the closest most appropriate receiving hospital. <i>Moderate Burn Classification:</i> transport to the closest most appropriate receiving hospital. <i>Major Burn Classification:</i> transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC). <i>CTP with associated burns:</i> transport to the most appropriate trauma hospital.</li><li>• Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be <b>considered</b> for transport to the closest most appropriate Burn Center. Trauma base station contacted shall be made.</li></ul> <p><b>MANAGE SPECIAL CONSIDERATIONS:</b></p> <p><b>Electrical Burns:</b> Place AED according to ICEMA protocols.</p> <ul style="list-style-type: none"><li>• Electrical injuries that result in cardiac arrest shall be treated as medical arrests.</li></ul>



**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 O<sub>2</sub> 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 O<sub>2</sub> 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>BLS Continued</u>	<u>Limited ALS Continued</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**

<b><u>Protocol Number</u></b>	<b><u>Protocol Name</u></b>
9010 AEMT	General Patient Care Guidelines
10160 AEMT	Axial Spinal Stabilization
10010/10020 AEMT	King Airway Device
14040 AEMT	Pediatric Cardiac Arrest
15030 AEMT	Trauma Triage Criteria and Destination Policy
12010 AEMT	Determination of Death on Scene