



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



City of Rancho Cucamonga
Council Chambers
10500 Civic Center Drive
Rancho Cucamonga, CA 91730

January 19, 2012
9:00 a.m.

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF MINUTES

September 15, 2011

III. INTRODUCTION OF NEW MEMBERS

Membership Report

IV. ICEMA UPDATE

- A. Legislative Update
- B. EOA Contract Negotiations
- C. EMS MISS I & II Status Report

INFO/ACTION

V. ICEMA MEDICAL DIRECTOR

- A. STEMI Center Update
- B. Stroke Receiving Centers Update
- C. Medication Shortage Update

INFO/ACTION

VI. STANDING EMS SYSTEM MANAGEMENT REPORTS

- A. Quarterly Trauma Hospital Reports
- B. Base Hospital Quarterly Reports
- C. Hospital Bed Delay Reports
- D. Hospital Surveillance
- E. STEMI Reports

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VII. OLD BUSINESS

- A. Utilization of PBC Trust Fund

ACTION/APPROVE

VIII. NEW BUSINESS

- A. Election of Chair and Vice Chair
- B. 2011 Annual Report - First Reading
- C. Special Event Authorization - Los Angeles Police Revolver and Athletic Club, Inc. (Challenge Cup Baker to Vegas Relay)
- D. Field Treatment Site Plan
- E. General Protocols (Comments will be distributed on 1/17/12)
 - 1. Draft Minimum Documentation Requirements for Transfer of Patient Care
 - 2. Draft ICEMA Abbreviation List

ACTION/APPROVE

3. 2010 BLS/ALS Standard Drug and Equipment List
4. 7020 EMS Aircraft Standard Drug and Equipment List

IX. COMMITTEE/TASK FORCE REPORTS

X. OTHER/PUBLIC COMMENT

XI. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

XII. NEXT MEETING DATE AND LOCATION

March 15, 2012

ICEMA

1425 South "D" Street

San Bernardino, CA 92415-0060

XIII. ADJOURNMENT

The San Bernardino 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.



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE



Richard Sewell Training Center
2824 East W Street - Building 302
San Bernardino, CA 92408

September 15, 2011

COMMITTEE	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Jim Holbrook	EMS Training Institution	<input checked="" type="checkbox"/> Reza Vaezazizi	Medical Director
<input checked="" type="checkbox"/> Diana McCafferty	Private Ambulance Provider	<input checked="" type="checkbox"/> Virginia Hastings	Executive Director
<input checked="" type="checkbox"/> Margaret Peterson	Hospital Administrator	<input checked="" type="checkbox"/> Denice Wicker-Stiles	Assistant Administrator
<input checked="" type="checkbox"/> Stephen Miller	Law Enforcement	<input checked="" type="checkbox"/> George Stone	PBC Program Coordinator
<input checked="" type="checkbox"/> Michael Smith	Fire Chief	<input checked="" type="checkbox"/> Sherri Shimshy	EMS Nurse
<input type="checkbox"/> Troy Pennington	Physician -Level II	<input type="checkbox"/> Patricia Eickholt	EMS Nurse
<input type="checkbox"/> Art Andres	EMT-P - Public Sector	<input checked="" type="checkbox"/> Chris Yoshida-McMath	EMS Trauma Nurse
<input checked="" type="checkbox"/> Rick Britt	Communication	<input checked="" type="checkbox"/> Ron Holk	EMS Nurse
<input checked="" type="checkbox"/> Allen Francis	Nurse - MICN	<input checked="" type="checkbox"/> Mark Roberts	EMS Technical Consultant
<input type="checkbox"/> Pranav Kachhi	Physician - ER	<input type="checkbox"/> Jacquie Martin	Secretary
<input checked="" type="checkbox"/> Roy Cox	Air Ambulance Provider		
<input type="checkbox"/> Vacant	City Manager		
<input type="checkbox"/> Vacant	Consumer Advocate		
<input type="checkbox"/> Vacant	Physician - Level I		
<input type="checkbox"/> Vacant	EMT-P - Private Sector		
Bob Gooch	United Steelworkers	Leigh Overton	SB County Fire
Joseph Guarrera	Apple Valley FD	Leslie Parham	SB County Fire
Bill Jones	San Manuel FD	Joy Peters	ARMC
Veronica Kennedy	Morongo Basin Ambulance	Joe Powell	Rialto FD
Ramon Lomeli	Morongo Basin Ambulance	Art Rodriguez	Desert Ambulance
Michael May	LLUMC	Ray Ramirez	Ontario FD
Mike McMath	Redlands FD		

I. CALL TO ORDER

The meeting was called to order at 9:02 a.m.

II. APPROVAL OF MINUTES

The July 21, 2011, EMCC meeting minutes were reviewed. Stephen Miller motioned to approve minutes; Roy Cox seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

III. PRESENTATION - IMAGETREND

Mark Roberts introduced Dario Zaiman, Sales Manager, who presented a short presentation of the ImageTrend software.

The following are some highlights of the presentation:

- System is Windows based, does not require internet access, and runs on remote disconnect tablet PCs.
- System is configurable, depending upon required service level.
- Different templates can be created.
- Fields marked in red are mandatory and must be completed.
- Information can be completed at patient's side or in the ambulance.
- There is a field for "repeat patient" and can be configured to hold information for 30 days or whatever determined length decided.
- All cardiac monitors can be integrated.
- Active protocols can be configured into the system.
- Depending upon hardware, signatures can be captured.
- Language can be changed so patients can read.

IV. ICEMA UPDATE

A. Legislative Update

Virginia Hastings reported that 2011 legislative session has ended. Important bills being followed are as follows:

AB 210 has been turned into a 2-year bill and is now being carried by Hernandez and renumbered as AB 1387. The coalition's intent is to keep active in hopes of reaching some agreement on language by the time the Legislature reconvenes.

Also, AB 1245 in its last form would allow EMSA to develop regulations for Emergency Medical Responders (EMRs). Language added would have prevented any group from certifying EMRs if they did not have an approved training program in place before January 1. This bill had tremendous opposition, especially by rural counties, EMS administrators, and other groups. The bill was passed by both the Assembly and Senate, but sent back to the Senate by the Governor's office. She is not sure if it will be brought back in the next session.

The newly appointed EMSA Director, Dr. Backer, has suspended the Chapter 13 Task Force for at least 90 days due to heavy EMSA workloads and the need to clarify the proposed AB 1387 legislation with expected outcome of the Chapter 13 Task Force.

Virginia Hastings noted that she also attends a work group with Dr. Gausche and others throughout the State to develop the first pre-public comment draft for EMS for Children regulations.

B. EOA Contract Extension Negotiations

Virginia Hastings reported that representatives of the Fire Chiefs Association and private providers continued meeting to discuss EOA contract extensions.

C. EMS MISS Status Report

EMS MISS Report is included in agenda packet for reference.

V. ICEMA MEDICAL DIRECTOR

Dr. Vaezazizi announced a change in EMS Nurse assignments. Chris Yoshida-McMath will be the point person for all specialty programs, which includes STEMI, Trauma and Stroke programs. Patty Eickholt will primarily focus on education. ICEMA is taking on an ambitious educational agenda, starting with the adoption of Ninth Brain software as a tool to reach out directly to providers with targeted education driven by our own QI experience. Sherri Shimshy will continue in the QI role with more upcoming projects.

A. STEMI System Update

Dr. Vaezazizi stated that the STEMI data have been posted on the ICEMA website. There are no significant trend changes other than the numbers are down. This may be due to reporting issues, not necessarily less patients.

B. Stroke Receiving Centers Update

Dr. Vaezazizi reported that there was a delay in the approval of the Stroke program. The item is scheduled to return to the Board for approval on September 27th. Once approved, the anticipated implementation date will be November 1st with a phase in process that could take up to six (6) months to achieve. More updates to come.

C. CQI Project - Pediatric Intubation

Dr. Vaezazizi reported that the pediatric intubation project is scheduled to start October 1st. All pediatric field intubations will be 100% reviewed. ICEMA wants a review within three (3) days, not retrospective review in 30 days. Electronic tags will be placed on ePCRs so ICEMA is notified when a field pediatric intubation has occurred; providers will be contacted and PCRs reviewed immediately.

D. Medication Shortage Update

Dr. Vaezazizi stated that the latest shortage reported is magnesium sulfate. He was happy to report that magnesium sulfate is one of those drugs that is rarely used but would hate to be in a situation where it is needed but not available. ICEMA is working with providers for restocking alternatives. Sherri Shimshy is the point person for medication shortages.

VI. STANDING EMS SYSTEM MANAGEMENT REPORTS

The following reports are available for review at http://www.sbcounty.gov/sbcounty_reports.aspx:

- Trauma Reports (Quarterly)
- Base Hospital Statistics (Quarterly)
- Bed Delay Reports
- Prehospital Data Reports
- Reddinet Assessment Reports
- STEMI Center Reports

VII. OLD BUSINESS

A. Utilization of PBC Trust Fund

Utilization of PBC Trust Fund is included in agenda packet for reference.

VIII. NEW BUSINESS

A. General Protocols

The following protocols were approved after discussion and no changes:

1. 11100 Burns-Adult

Stephen Miller motioned to approve; Margaret Peterson seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

2. 14070 Burns-Pediatric

Stephen Miller motioned to approve; Allen Francis seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

4. 15020 Trauma-Pediatric

Stephen Miller motioned to approve; Diana McCafferty seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

5. 15030 Trauma Triage Criteria and Destination Policy

Stephen Miller motioned to approve; Diana McCafferty seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

The following protocol was approved after further discussion and with changes as noted:

3. 15010 Trauma-Adult

a. On Page 1 under ALS INTERVENTIONS: Remove "if indicated" and move to the end of sentence after "needle cricothyrotomy" and put in parenthesis to read "-The paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated)."

b. Add the word THEN in bold before "Transport to the closest receiving hospital ...".

Stephen Miller motioned to approve as amended; Roy Cox seconded.

MSC:

Ayes - 8

Noes - 0

Abstaining - 0

VIII. COMMITTEE/TASK FORCE REPORTS

None

IX. OTHER/PUBLIC COMMENT

None

X. COMMITTEE MEMBER REQUESTS FOR NEXT MEETING

None

XI. NEXT MEETING DATE AND LOCATION

November 17, 2011 (Meeting Cancelled)

Richard Sewell Training Center

2824 East W Street, Building 302

San Bernardino, CA 92408

XII. ADJOURNMENT

EMCC Meeting was adjourned at 10:48 a.m.

VH/jlm



SAN BERNARDINO COUNTY EMCC MEMBERS APPOINTMENTS/MANDATORY AB 1234 ETHICS TRAINING



SEAT #	MEMBER NAME	EMCC POSITION	APPOINT. DATE	APPOINT. EXPIRES	MEMBER STATUS	AB1234 COMP. DATE	AB1234 ETHICS EXPIRES
1	McCafferty, Diana	Private Ambulance Provider	3/22/2011	1/31/2013	CURRENT	7/15/2011	7/15/2013
2	Holbrook, Jim	EMT-P Training Program	3/22/2011	1/31/2015	CURRENT	6/27/2011	6/27/2013
3	Peterson, Margaret	Hospital Administrator	3/22/2011	1/31/2015	CURRENT		
4	VACANT	ED Physician – Non-Trauma					
5	VACANT	City Manager, Deputy City Manager, or Assistant City Manager					
6	VACANT	Consumer Advocate					
7	Smith, Michael	Fire Chief	3/22/2011	1/31/2015	CURRENT	4/21/2010	4/21/2012
8	Miller, Stephen	Law Enforcement	1/10/2012	1/31/2016	CURRENT	7/01/2010	7/01/2012
9	Andres, Art	EMT/EMT-P - Public Sector	1/10/2012	1/31/2016	CURRENT	8/09/2011	8/09/2013
10	Britt, Rick	Emergency Medical Dispatch (PSAP)	3/22/2011	1/31/2015	CURRENT	7/28/2011	7/28/2013
11	Francis RN, Allen	Nurse - MICN	1/10/2012	1/31/2016	CURRENT	3/13/2010	3/13/2012
12	Pennington MD, Troy	Physician - Level II	6/7/2011	1/31/2014	CURRENT	7/14/2010	7/14/2012
13	Cox, Roy	Air Ambulance Provider	3/22/2011	1/31/2015	CURRENT	9/24/2010	9/24/2012
14	Catalano MD, Richard	Physician - Level I	12/6/2011	1/31/2015	CURRENT		
15	Art Rodriguez	EMT/EMT-P - Private Sector	11/15/2011	1/31/2015	CURRENT	11/30/11	11/30/13

Updated 1/10/12
/jlm

Staff Report - EMCC

EMS Management Information & Surveillance System – MISS I and MISS II (ImageTrend)

Following a thorough and deliberative process, including an independent evaluation committee, ICEMA selected ImageTrend as the software to move the ICEMA Region into the next era of EMS system data management. ICEMA's Governing Board approved the ImageTrend contract in November 11, 2011. We have affectionately (officially) named this upgrade as "EMS MISS II".

ICEMA will continue to provide EMCC minimal Staff Reports on EMS MISS I until we are completely transitioned to EMS MISS II; however, the majority of our staff reports will now concentrate on implementation of EMS MISS II.

I am also pleased to report that ICEMA has received the expressed support of the San Bernardino County Fire Chiefs' Association for the EMS MISS II (Image Trend) process being implemented by ICEMA.

MISS II

The ImageTrend Software satisfies and exceeds minimum requirements of the California Health and Safety Codes and the California Code of Regulations pertaining to prehospital care patient care documentation, specialty care documentation, medical control, quality assurance. It satisfies CEMSIS and NEMSIS and at the same time allows for flexibility within an EMS system to add information that the system might deem necessary. As you know, complete patient care information is required to provide continuous information on the quality of care, identify educational needs, identify needed protocol changes, and participate in state and federal funding opportunities.

We have begun the rollout of EMS MISS II. The beta testing phase is scheduled to begin in May 2012 with San Bernardino City Fire and AMR Redlands. Training is planned for agency administrators and field providers during the second and third quarters of 2012.

To comply with the Health and Safety Code and Regulations governing prehospital care personnel and systems, all EMS providers in the ICEMA Region are required to implement EMS MISS II.

MISS I

ICEMA SERVER

ICEMA has received the follow:

1. 2010 - 196,506 ePCR's
2. 2011 - 223,844 ePCR's
3. January 1, 2011 - June 30, 2011 - 110,220 ePCR's
4. December 2011 - 19,570 ePCR's

PENDING MOU's

CAL FIRE – Yucaipa and San Bernardino

PENDING DEPLOYMENTS

Mono County Paramedic's - Mono County

Crest Forest Fire Protection District - San Bernardino County

Symons Special Events - San Bernardino County

Sheriff's Search and Rescue - San Bernardino County

THIRD PARTY INTERFACE TO MISS

ICEMA is successfully receiving data through a third party interface from Desert Ambulance and Mercy Air. Further efforts to transfer/receive data from CONFIRE have been discontinued and staff activities turned to implementation of EMS MISS II.

Mark Roberts
01/19/12

Staff Report - EMCC

UTILIZATION OF PBC TRUST FUND (LIQUIDATED DAMAGES)

Current Balance (December 29, 2011): \$1,000,485.61

Incidental Expenses:

During the October 2010 meeting, the EMCC approved the use of liquidated damages for incidental expenses related to the MISS project or performance based contracts not to exceed \$5,000.

APPROVED INCIDENTAL BUDGET			\$5,000
Expenses:			
Item	Vendor	Date	Amount
Toughbook batteries	Sarcom	12/14/11	\$3,450.22
Total Spent			\$3,450.22
Incidental Account Balance Remaining			\$1,549.78

Additional Expenses for FY 2011-12:

APPROVED INCIDENTAL BUDGET	Vendor	Amount	\$40,000
Expenses FY 2012:			
Paper	Staples	\$4,281	\$4,281
Toner	Daisy Wheel	\$11,491	\$11,491
Subtotal			\$15,772
Remaining Balance			\$19,825

Trust Fund Expenditure History

September 2009	Printer Paper and Toner	\$28,000
January 2010	150 Ruggedized Flash Drives	\$5,000
May 2010	Printer Paper and Toner	\$25,000
July 2010	Additional Printers	\$5,177
January 2011	Printer Paper and Toner Increase	\$15,000
May 2011	Additional Printers	\$12,500

Ed Segura
1/19/12



SAN BERNARDINO COUNTY EMERGENCY MEDICAL CARE COMMITTEE

2011
ANNUAL REPORT



INTRODUCTION

This writing is to document the San Bernardino County Emergency Medical Care Committee (EMCC) processes for 2011. Essentially the focus of the EMCC was to provide a platform for the diverse groups and individuals which form the Emergency Medical Services System. It also acts as an advisory group to the Board of Directors for Inland Counties Emergency Medical Agency (ICEMA).

The local EMS system continues to mature and is formally exploring patient outcomes and other evidence based processes. San Bernardino County Emergency Services continues to advance the care and other services to the ill or injured.

EMCC MEMBERSHIP

The 2011 EMCC members were:

SEAT NO.	MEMBER	POSITION
1	Diana McCafferty	Private Ambulance Provider (Vice-Chair)
2	Jim Holbrook	EMT-P Training Institution (Chair)
3	Margaret Peterson	Hospital Administrator
4	Pranav Kachhi, MD	ED Physician - Non-Trauma
5	Vacant	City Manager/Deputy City Manager/Assistant Manager
6	Vacant	Consumer Advocate
7	Michael Smith	Fire Chief
8	Stephen Miller	Law Enforcement
9	Art Andres	EMT/Paramedic - Public Sector
10	Rick Britt	Emergency Medical Dispatch/Communications
11	Allen Francis	Nurse – MICN
12	Troy Pennington, MD	Physician - Level II
13	Roy Cox	Air Ambulance Provider
14	Vacant	Physician - Level I
15	Vacant	EMT/Paramedic - Private Sector

The EMCC positions representing City Manager and Consumer Advocate continued to be unfilled during the 2011 sessions. These vacancies originated during the 2009 sessions, and ICEMA has been working to fill these positions. On April 5, 2011, the Board of Supervisors approved revisions to the EMCC ordinance. The EMCC bylaws were revised to reflect these approved changes. These changes will result in two accredited field paramedics, one representing public and one representing private agencies. Art Andres continues to serve in the public sector role and the new position for accredited EMT/Paramedic private sector will be filled during the 2012 sessions. The other change to the EMCC membership will be the addition of a physician from a Level I Trauma Center.

EMCC members are required to be in compliance with the requirements for Ethics training as defined by Article 2.4 of Chapter 2 of Title 5 of the Government code (AB 1234).

MANPOWER AND TRAINING

Both on-line and off-line medical control protocols continue to assure medical control of emergency medical care. A series of protocols, both regular updates and emergency protocols, were discussed during the 2011 EMCC sessions. The protocol changes were stimulated by

changes in scientific or local system needs. Additionally, an AD HOC Committee was formed to evaluate minimum data requirements for patient care records and to standardize abbreviations. Emergency medical care and quality patient outcomes and the measurements of those outcomes are continuing to advance within the system. The implementation of an accurate measure and documentation of outcomes of emergency medical care were more fully realized system wide and will remain a dynamic process. Following the full system wide implementation of electronic data collection, the review of system and quality assurance measures will need to be added to the processes already instituted.

The local training institutions, Victor Valley and Crafton Hills College, have implemented student training sessions on the use of electronic patient care documentation. The system continues through local provider and hospital based agency processes to forward the educational and training needs of the basic and advanced life support personnel system wide.

COMMUNICATIONS

The ability to communicate system issues including waiting to off load patients has shown progress as our larger system continues to meet these system challenges. The entire EMS system continues to explore and advance communications among all groups.

TRANSPORTATION

ICEMA reported on discussions of transportation issues during the 2011 sessions. These committee deliberations were to extend existing performance based contract scheduled to expire during the 2012 session. External confounding issues at the state level have influence these discussions. Continued funding from the performance based contract fines was added to other funding sources to augment the system needs of the region. The EMCC endorsed the expenditure of \$750,000 for the purchase of a new EMS data system from ImageTrend.

ASSESSMENT OF HOSPITALS AND CRITICAL CARE CENTERS

The EMCC received standing emergency medical services system management reports at each of the scheduled meetings. These standing reports included quarterly reports for Trauma systems and base hospital statistics and the monthly reports of electronic patient care reports, hospital bed delays, medication / procedures / and type of patient summary reports, and hospital surveillance reports. These standing reports assist the overall system as it continues to explore and advance in communication and systems knowledge between all groups.

MEDICAL CONTROL

The medical control protocols and system processes continue to assure overall medical control of system. Twenty-two (22) protocols, both regular updates and new protocols, were discussed during the 2011 EMCC sessions. The protocol changes were stimulated by changes in scientific or local system needs. Based on State level regulatory changes, an entire medical control system for the Advanced Emergency Medical Technician (AEMT) was discussed and the EMCC endorsed thirty-three (33) protocols for this level of practitioner. The system continues through local provider and hospital based agency processes to forward the educational, training, and personnel needs of the basic and advanced life support personnel system wide.

Additionally, MEDCOR implemented a process to enhance the remote EMS services to include advanced life support to the employees of the Molycorp Mountain Pass Mine near the Nevada border

DATA COLLECTION AND EVALUATION

The EMS system continued to document progress in data collection and analysis during the 2011 sessions. Substantial agency(s) and personnel time were required in order to accurately collect, review, analyze, and compile reports for various discussions and decision making loops. Continuing efforts have been made toward fully implementing electronic collection system wide. The system is moving out of the initial phase and some system outcome data exists.

The transportation industry continues to be further along on the continuum of electronic transfer than public response agencies. During the 2011 session the following San Bernardino County providers are sending data to the ICEMA server on a daily basis:

- 1) American Medical Response (AMR) Rancho
- 2) AMR Redlands
- 3) AMR Victorville
- 4) Baker EMS - Baker
- 5) Baker EMS - Needles
- 6) Barstow Fire Department
- 7) Big Bear City Fire Valley Paramedic Service
- 8) Big Bear Lake Fire Protection District
- 9) Desert Ambulance
- 10) Fort Irwin Fire Department
- 11) Mercy Air
- 12) Morongo Basin Ambulance Association
- 13) Morongo Valley Fire Department
- 14) Running Springs Fire Department
- 15) San Bernardino City Fire Department
- 16) San Bernardino County Sheriff's Aviation
- 17) San Manual Fire Department
- 18) Upland Fire Department - Air
- 19) Upland Fire Department - Ground

Memorandum of Understandings and full implementation is expected for the following agencies:

- 1) Crest Forest Fire Department
- 2) Sheriff's Search and Rescue

Despite a great deal of effort the transfer and receipt of CONFIRE data was not successful.

The following fire departments remain outside of the ICEMA Management Information and Surveillance System (MISS):

- 1) Apple Valley Fire Department
- 2) CAL FIRE - City of Highland Fire Department
- 3) CAL FIRE - City of Yucaipa Fire Department
- 4) Chino Valley Fire Department
- 5) Colton Fire Department

- 6) Combat Center Fire Department - Twentynine Palms
- 7) Loma Linda Fire Department
- 8) Marine Corp Logistics Base - Barstow
- 9) Montclair Fire Department
- 10) Ontario Fire Department
- 11) Rancho Cucamonga Fire Department
- 12) Redlands Fire Department
- 13) Rialto Fire Department
- 14) San Bernardino County Fire Department

PUBLIC INFORMATION AND EDUCATION

The EMS system continues to provide quality care with the STEMI system processes and the implementation of a new Stroke receiving process. Both of the system construct highlight successful regionally based programs. The EMCC had presentations from the Crest Forest Fire Department on a multiple patient incident and ImagineTrend on issues impacting the electronic documentation system.

DISASTER RESPONSE

During this past year our local agencies responded to significant regional and state-wide large scale issues including the potential for significant threats. Crest Forest presented an overview of a multi-casualty response.

CONCLUSION

It has been the goal of the EMCC to allow broad-based system participation and discussions and believe these activities have advanced the local EMS system. The EMCC applauds the EMS system and the participants as an amazing collection of the best and brightest in California.

Staff Report - EMCC

Special Event ALS Non-transport Authorization - Los Angeles Police Revolver and Athletic Club, Inc. (Challenge Cup Baker to Vegas Relay)

To accommodate the needs of the Los Angeles Police Revolver and Athletic Club (LAPRAC) and to ensure mandated medical control, including proper accreditation over paramedics, ICEMA has developed a new ALS authorization classification - Special Event ALS Non-transport Authorization.

The LAPRAC's annual Challenge Cup/Baker to Vegas Relay event is scheduled for April 21 - 22, 2012 and 270 teams are anticipated to compete, six (6) of which are from other countries including Canada and Europe. Approximately 6,000 people attend and/or participate in the annual event. Teams are comprised of Probation Officers, District Attorneys, U.S. Attorneys and full time civilian police personnel. The Baker to Vegas Relay is the most "positive" event offered to law enforcement officers today. It gives them a reason to maintain a physical fitness program so as to help them better perform their duties. The original ideals of the race continue: teamwork, camaraderie, physical fitness and competition.

Staff has determined that this new classification will enable LAPRAC to meet the requirements as specified in the Health and Safety Code as well as the public health, safety, welfare, convenience and necessity requirement for the granting of ALS authorization.

Endorsement of this Special Event ALS Authorization would allow LAPRAC to provide ALS service to participants of the race, once approved by the ICEMA Governing Board. This is an event-specific authorization and will be so noted in the contract between ICEMA and LAPRAC.

Staff recommendation:

EMCC endorse Special Event ALS Authorization to LAPRAC.

Staff Report - EMCC

SAN BERNARDINO COUNTY - FIELD TREATMENT SITE PLAN

The local emergency medical services agency (LEMSA) is statutorily responsible for the planning, coordinating, and evaluating local EMS systems, including establishing policies and procedures for patient distribution within the Operational Area (OA). The Medical and Health Plan or Emergency Operations Manual (EOM) prepared jointly by California Emergency Medical Services Authority (EMSA) and California Department of Public Health (CDPH) requires that the plan must include preparedness, response, recovery, and mitigation functions, per State of California Health and Safety Code Division 2.5, Chapter 3, Article 4 Medical Disasters. The Field Treatment Site (FTS) Plan is to be used when the OA and local hospitals are overwhelmed during an incident(s). FTSs can be established to hold and treat patients until they can be transported to the appropriate medical facility, either within or outside the OA. A FTS can be established at a pre-designated location or at the scene of the incident. During these types of incidents it is critical that all components of the EMS system function within a coordinated framework to expand capacity for the care, distribution, transportation, and tracking of the patients. A FTS should generally never exceed more than 48 hours in duration.

ICEMA assures that plans, policies and procedures for managing the response to MCI's and establishing FTS's are consistent with FIRESCOPE, ICS, and SEMS principals, and all ICEMA policies and procedures.

ICEMA wants to thank the following system participants who assisted us in preparing the FTS plan:

Joe Guarrera, Apple Valley Fire District
Bernie Horak, San Bernardino City Fire Department
Bill Jones, San Manuel Fire Department
Bob Tyson, Redlands Community Hospital
Leslie Parham, San Bernardino County Fire Department
Art Rodriguez, Desert Ambulance
Veronica Kennedy, Morongo Basin Ambulance

Staff recommendation:

EMCC endorse San Bernardino County - Field Treatment Site Plan.

Paul Easterling
1/19/12

FIELD TREATMENT SITE PLAN

January 2012



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Concept of Operations

Duration	1 to 48 Hours
Types of Events	Multi/mass Casualty Event/Incident, such as <ul style="list-style-type: none"> ● Earthquake ● Bomb blast ● Transportation accident ● Any event where the local capacity for transporting patients is overwhelmed (per state plan)
Function	<ul style="list-style-type: none"> ● Patient congregation / registration ● Triage ● Medical care ● Patient holding / evacuation
Scope of Medical Care	<ul style="list-style-type: none"> ● EMS medical care (ALS and/or BLS) <ul style="list-style-type: none"> ○ Wound care ○ Control of bleeding ○ Treatment of shock ○ Fluid replacement (ALS only - when available) ○ Splinting of fractures ○ Pain relief (ALS only – when available) ○ Initial care of burns ● Mental health support
Staffing	Staffing provided by EMS personnel, with surge from neighboring jurisdictions, regional support (through Inland Counties EMS Agency (ICEMA), Department of Public Health (DPH) staff (admin), Disaster Health Volunteers (DHV), and the Medical Reserve Corp (MRC)
Location	<ul style="list-style-type: none"> ● Near incident site¹ ● Near hospital ● Pre-designated sites geographically and/or strategically located
Objective	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 San Bernardino County will surpass one hour.
Assumptions	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.

¹ During a localized MCI event (e.g. bus crash, bleacher collapse), the IC, MGS, and the MHOAC Program 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.

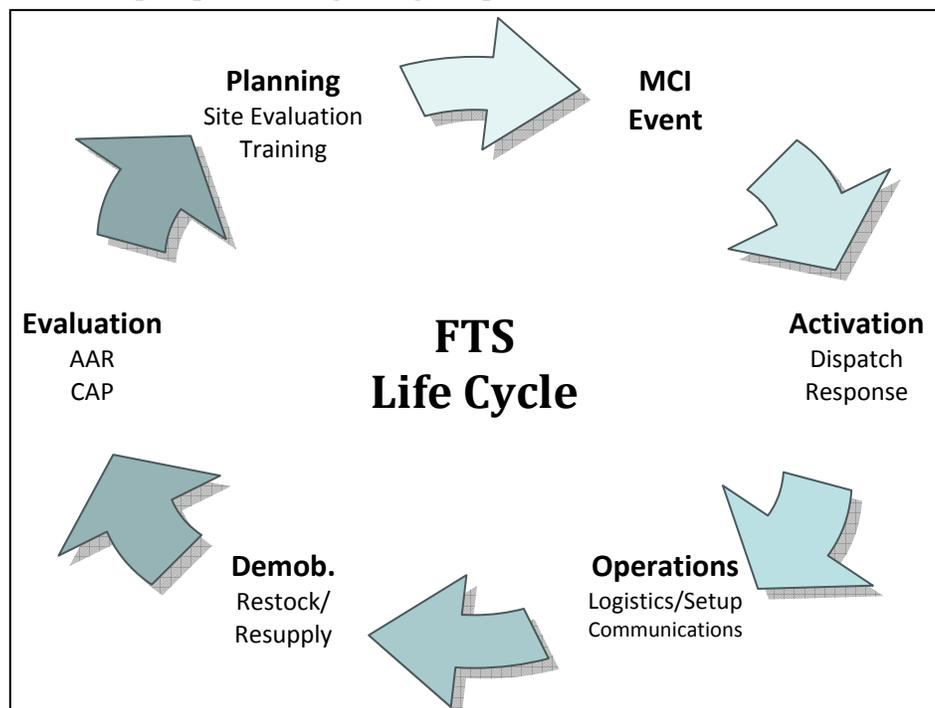
The Inland Counties EMS Agency (ICEMA) has identified that the existing EMS system can transport up to 20 patients within the first hour of a major event, such as a bomb blast. Therefore, an FTS location is a suitable option when there are expected to be more than 20 patients or there will be delays 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. 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 San Bernardino 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. The appropriate Communications Center will in turn notify the MHOAC, or the MHOAC designee, i.e., EMS Duty Officer (EMSDO).. 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 San Bernardino County for the next deployment of the FTS plan.

For clarification, the following crosswalk provides a comparison of the various functions within the healthcare continuum.

Location Name	Definitional Considerations	Possible Reasons for Site Activation (one or more)
<p>Field Treatment Site</p>	<p>Definition: A temporary site for triage, emergency medical treatment, and management and care of casualties in a field setting usually when permanent medical facilities are limited, overwhelmed, or unavailable. Stabilized patients requiring acute inpatient care are transported to receiving facilities when available.</p> <p>FTSs are generally intended to operate for up to 48 hours or until injured patients stop arriving.</p> <p>Activation and Lead: Activated by EMS (EF-8) for onsite field incidents, may also be activated by Operational Area EOC Medical Health Branch (EF-8).</p>	<ul style="list-style-type: none"> • A casualty incident expected to exceed local emergency or hospital capacity. • Delay in arrival of sufficient levels of medical aid • A protracted, large-scale response with multiple casualties • A planned event where the provision of medical treatment is anticipated, not necessarily when resources are overwhelmed (e.g., Large Mass Gathering, Music Festival, etc.).
<p>Medical Shelter</p>	<p>Definition: A temporary shelter which provides sufficient medical care to ensure that sheltered individuals maintain their usual level of health when displaced during an incident. These sites are typically located outside the impact zone and serve individuals from the impacted community with needs that require skilled medical care, but do not require hospitalization, or have an acute emergency medical condition.</p> <p>Activation and Lead: Typically activated by Public Health (EF-8) with support from social services and select non-governmental organizations (EF-6).</p>	<ul style="list-style-type: none"> • Displacement of a large population with medical needs • The immediate needs of the incident exceed the ability to accommodate the impacted population in “like facilities” • A need to reduce the strain on the overall healthcare system when resource requirements exceed resource capability • A higher level of in medical skill, resources or infrastructure is required by individuals within a General Population Shelter(i.e., those requiring continuous monitoring) • The immediate needs of the incident do not allow for the appropriate level of activation of the emergency plans or agreements and contingencies are

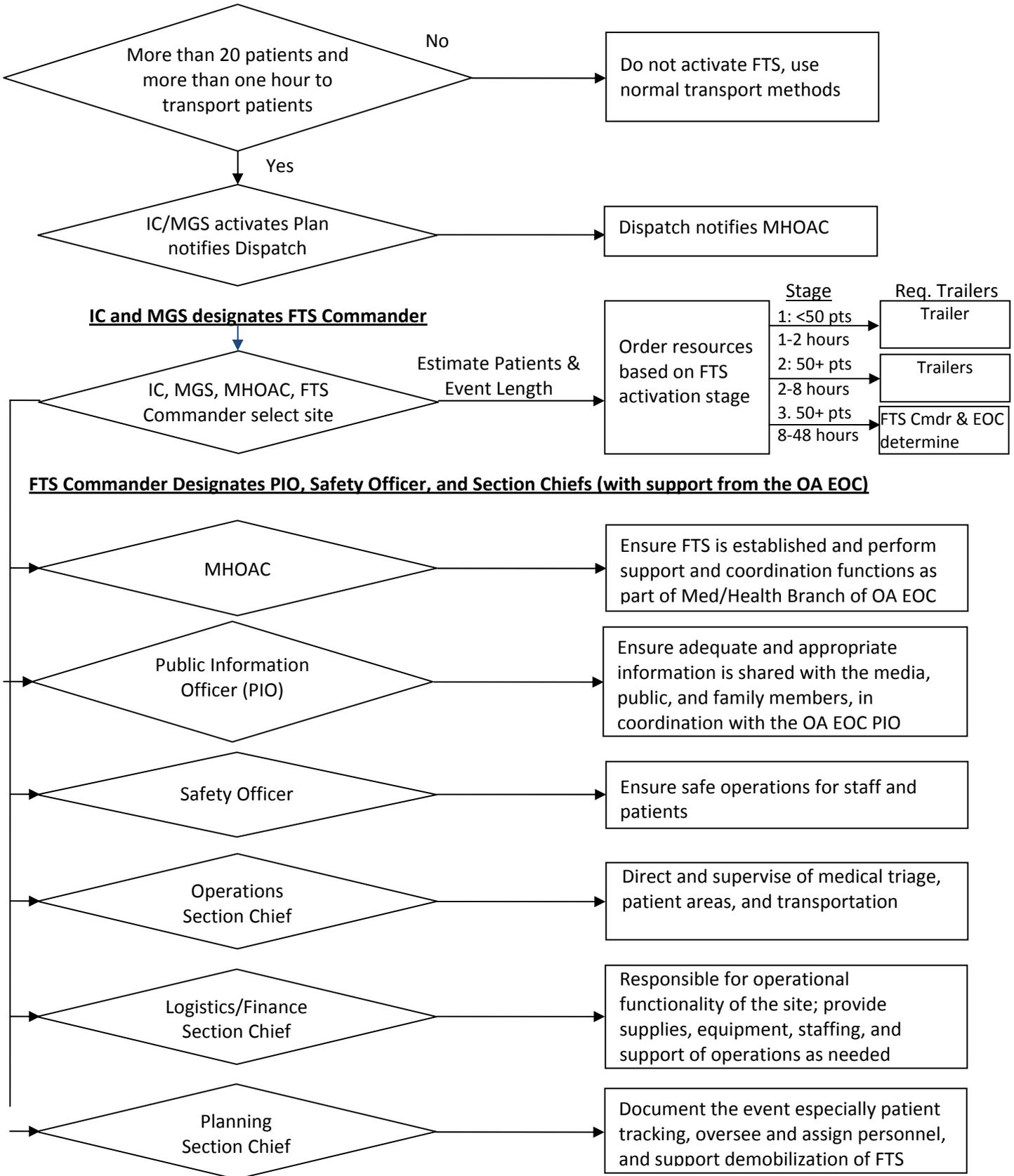
**Government
Authorized
Alternate Care
Site**

Definition: A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare service to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These sites are not part of the expansion of an existing healthcare facility, but rather are designated under the authority of the local government. A Government Authorized Alternate Care Site may be a Mobile Field Hospital.

Activation and Lead: Typically activated by Public Health and/or State EMS Authority (EF-8) utilizing a public-private partnership and CALMAT teams.

- The overall healthcare system has exhausted all available resources through surge, additional capacity still required
- Incident creates need for an increased localized acute medical care capacity

Activation Algorithm



Roles and Responsibilities (utilizing the town and/or OA EOP/EOC, and ICS/SEMS)

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

FTS Functions	On-Scene Command	OA Public Safety Dispatch	Hospitals, Clinics	OA EOC Environmental Health Branch	OA EOC Mental Health Branch	OA EOC Medical/Health Branch (MHOAC)	Town/OA EOC Construction and Engineering Branch	Town/OA EOC Law Enforcement Branch or Local Law Enforcement	OA EOC Care and Shelter Branch	Town/OA EOC Logistics Section	Other
Command and Control (Scene)	●										
Coordination if more than one EMS FTS						●					
Notification		●	○	○	○	○			○	○	
Provision of Personnel		○	○	○	○	○				● ²	○ ³
Medical Supply			○			●				○	○ ⁴
Medical Equipment			●			●				●	○ ⁴
Non-Medical Supply				○						●	○ ⁴
Communications Equipment		○								●	○ ⁴
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			○							●	○ ⁵
Alternative Ground Transportation										●	
Public Information	●				○						● ⁶

² 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.

³ DHV, MRC, CAL-MAT, DMAT, and Federal Health Care workers

⁴ Vendors

⁵ Logistics Air Operations contacts Regional Emergency Operations Center (REOC) for assistance from the National Guard and other military sources.

⁶ 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 San Bernardino County Facility Profile)
<input type="checkbox"/> Establish a Memorandum of Understanding with these sites as necessary
<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.

Scene Incident Commander (IC) and/or Medical Group Supervisor (MGS)
<input type="checkbox"/> Activate the FTS Plan
<input type="checkbox"/> Notify Comm Center (ConFire) 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
Comm Center (ConFire) Dispatch
<input type="checkbox"/> Contact the Public Health and/or ICEMA EMS Duty Officer, as well as OA Law and Fire Coordinators if not already notified.
San Bernardino County Public Health and/or ICEMA EMS Duty Officer (EMS or Department of Public Health)
<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
ICEMA and Public Health DOC (as part of the Medical/Health Branch of the OA EOC)
<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
FTS Commander
<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 2: 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.

FTS Commander
<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 DOC every hour
<input type="checkbox"/> Establish and maintain communications with MGS and DOC
Operations Section Chief
<input type="checkbox"/> Using the site layout diagram (appendix 1), 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
Logistics Section Chief
<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 3: resource inventory and map)
<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"/> Generators/fuel
<input type="checkbox"/> Water
<input type="checkbox"/> Lighting
<input type="checkbox"/> Bathrooms
<input type="checkbox"/> HVAC
<input type="checkbox"/> Tents/shelters
<input type="checkbox"/> Consider requesting the EOC for logistical support, specifically food and water for staff and casualties
Planning Section Chief
<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 4) to FTS Commander and/or EOC
<input type="checkbox"/> Track needs when the FTS is demobilized
Finance Section Chief
<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

Logistics Section Chief
<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
Planning Section Chief
<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)
Finance Section Chief
<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

San Bernardino County

Designated Disaster Facilities

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: _____

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: Yes No Unknown

Year Built: _____ If before 1933, earthquake retrofitted: Yes No

Owner: _____ MOU in place: Yes No Not needed

Is there the potential for mixed usage during a disaster (the owner plus the responding agency)? Yes No

Has the facility been identified for use at the time of a disaster by other agencies? Yes No

Who? _____

Point of Contact (POC) w/key (Name/Title): _____

Work #: _____ Cell #: _____ Home #: _____

POC for facility maintenance (Name/Title):

Work #: _____ Cell #: _____ Home #: _____

POC for site security (Name/Title):

Work #: _____ Cell #: _____ Home #: _____

Overall suitability of this site to support the indicated emergency response (FTS, ACS, POD, RSS, shelter long term – evacuation, shelter short term – warming, cooling), based on the following assessment of the exterior and the interior of the site/facility:

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

Potential limitations with this site (narrative):

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)? Yes No
2. If Yes, is a gate solid and able to be securely locked? Yes No
3. Is there a potential helicopter landing zone nearby? Yes No
4. Are there external hazards potentially useful to intruders (hiding places, items that could be used as weapons, missiles, or tools)? Yes No
5. Is there a parking lot? Yes No
 - a. # of spaces _____
 - b. # of marked ADA spaces meeting ADA requirements _____
6. Is there ADA access to the building (ramp, etc.)? Yes No
7. Is there adequate access and entry for emergency vehicles with a gurney? Yes No
8. Is there a separate loading dock/area? Yes No
9. Are there forklifts or pallet jacks available? Yes No
 - a. # of forklifts _____
 - b. # of pallet jacks _____
10. Is there access to the loading dock/area for a semi-trailer truck (18 wheeler)? Yes No
11. Is the responsibility for potential snow removal assigned? Yes No
12. Does flooding ever interfere with access to the parking and facility? Yes No
13. Is there the ability to lock down the building (all entrances/exits/windows)? Yes No
14. External lighting:
 - a. Is the entire perimeter lighted? Yes No
 - b. Is the parking area adequately lighted? Yes No
 - c. Is the exterior of the building, especially entry points, adequately lighted? Yes No
 - d. Are control switches for external lighting automatic (versus manual)? Yes No
 - e. Are control switches inaccessible to unauthorized persons? Yes No
 - f. Do any exterior lights have an auxiliary power source? Yes No

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

16. Can all street/road/highway access to the site be blocked off if necessary? Yes No

17. Could a secure route be ensured for access by supply or emergency vehicles? Yes No

18. Are there any facilities nearby which might pose a security threat (jail, halfway house, storage of hazardous materials, bars)? Yes No

Describe:

Are there any problems with vehicular traffic congestion in the area? Yes No

Describe:

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

Describe:

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 (circle): Low Average High

Shelter long term (circle): Low Average High

Shelter short term (circle): Low Average High

Comments (narrative):

Assessment of the Interior of the Site

1. Are all exterior doors solid core wood, metal clad, or metal? Yes No
2. Are all exterior doors equipped with cylinder locks, deadbolts, or solid locks? Yes No
3. Are all exterior doors equipped with intrusion alarms? Yes No
 - a. Where does the alarm system terminate (circle): commercial law enforcement
4. Is the main power source dependable? Yes No
 - a. Utility company (circle): SCE DWP
5. Is there an auxiliary power source/generator? Yes No
 - 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? Yes No
8. Are light switches key controlled? Yes No
9. When was the facility last inspected by the fire marshal? _____
10. Did the fire marshal approve the building? Yes No
 - a. If no, why not? _____
11. Does the building have functioning fire alarms? Yes No
12. Does the building have functioning smoke detectors? Yes No
13. Does the building have a sprinkler system? Yes No
14. Does the building have fire extinguishers? Yes No
 - a. If Yes, last inspected: _____
15. Does the building have emergency fire hoses/standpipes? Yes No
16. Does the building have a functioning and inspected AED? Yes No
17. Does the building have any first aid supplies? Yes No
18. Is there a written evacuation plan (fire, flood, earthquake, etc.) for the facility? Yes No
19. Are exits clearly marked? Yes No

20. Describe communications resources:
- a. PA system, intercom, overhead paging (describe):

 - b. Internet – none, dial-up, broadband, Wi-Fi (circle all that are available)
 - c. Computers available for emergency response personnel use (#): _____
 - d. Phone (# lines, phones, TDD capable):

 - e. FAX (# machines): _____
 - f. During tests, did 2-way radios transmit and receive clearly from inside the building? Yes No
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? Yes No
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? Yes No
34. Is there a large amount of cash retained in any office overnight, and if so, is there an adequate safe, vault, or strongbox? Yes No
35. Are there separate rooms/areas potentially available for the following:
- a. Staff rest/break room Yes No
 - b. Kitchen Yes No
 - 1) Stove (#): _____ Yes No

- 2) Microwave (#): _____ Yes No
- 3) Food supply and preparation area Yes No
- 4) Refrigerator (#): _____ Yes No
- 5) Freezer (#): _____ Yes No
- 6) Sink (#): _____ Yes No
- 7) Dishwasher (#): _____ Yes No
- 8) Waste disposal (#): _____ Yes No

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

Laundry – separate area or room with washers and dryers Yes No

Incident Manager – 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 Yes No

Triage – 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.) Yes No

Medical Counseling – private area/room for medical staff to counsel individuals or families regarding proposed medical intervention (prophy, vacc., Rx, placement) Yes No

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 Yes No

Secure Pharmaceutical Storage – temperature controlled, securable room near loading dock or staff entrance able to store medications, including refrigeration Yes No

- 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 five (5) beds Yes No
- Palliative Care –separate private room large enough for at least 5 cots and family members, able to move cots or gurney in/out Yes No
- Mortuary – separate secured area for temporary storage of bodies in body bags, near loading dock or staff entrance Yes No
- 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) Yes No
- Family – separate private area for families of affected persons to rest, eat, sleep, with shower and bathroom facilities Yes No
- Media Staging – separate area near loading dock/staff entrance, with ability to be securely separated from the public, large enough to conduct interviews/briefings Yes No
- Service Animals/Pets – separate room for affected persons with service animals or small pets in cages, kennels, on leash, and well controlled Yes No
- Environmental Supply Storage – room/area to store cleaning equipment, bathroom supplies, soap and hand sanitizers, etc., able to be secured Yes No
- 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 Yes No

Biohazard/Waste Disposal – secured room near loading dock or staff

entrance able to contain large bags of contaminated waste pending final

disposition

Yes No

Law Enforcement Holding – secured private room/area able to temporarily hold

individuals being detained by law enforcement

Yes No

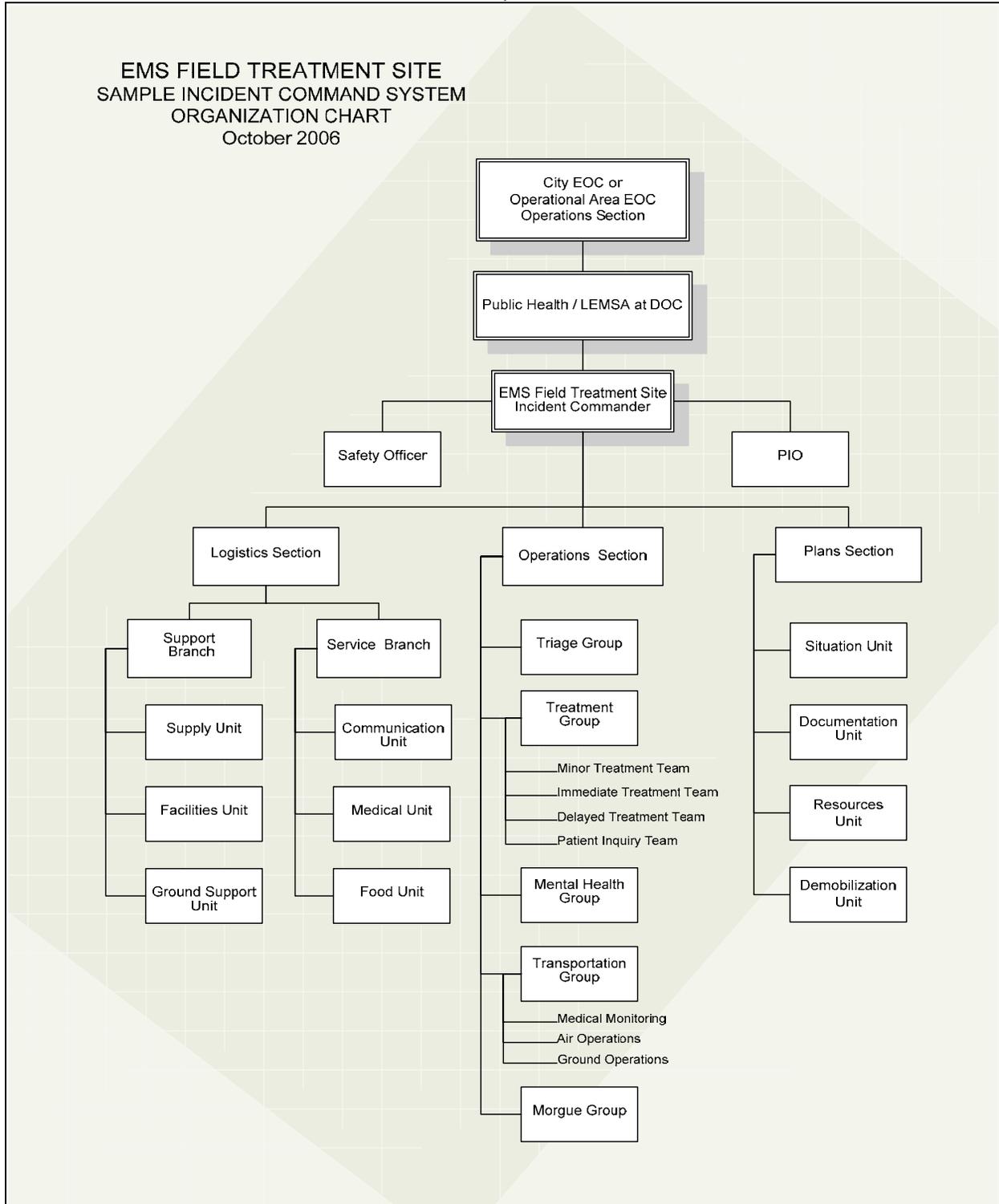
Based on this assessment of the **interior** of the site, the suitability of this site to support the indicated emergency response is:

FTS (circle):	Low	Average	High
ACS (circle):	Low	Average	High
POD (circle):	Low	Average	High
Shelter long term (circle):	Low	Average	High
Shelter short term (circle):	Low	Average	High
Comments (narrative):			

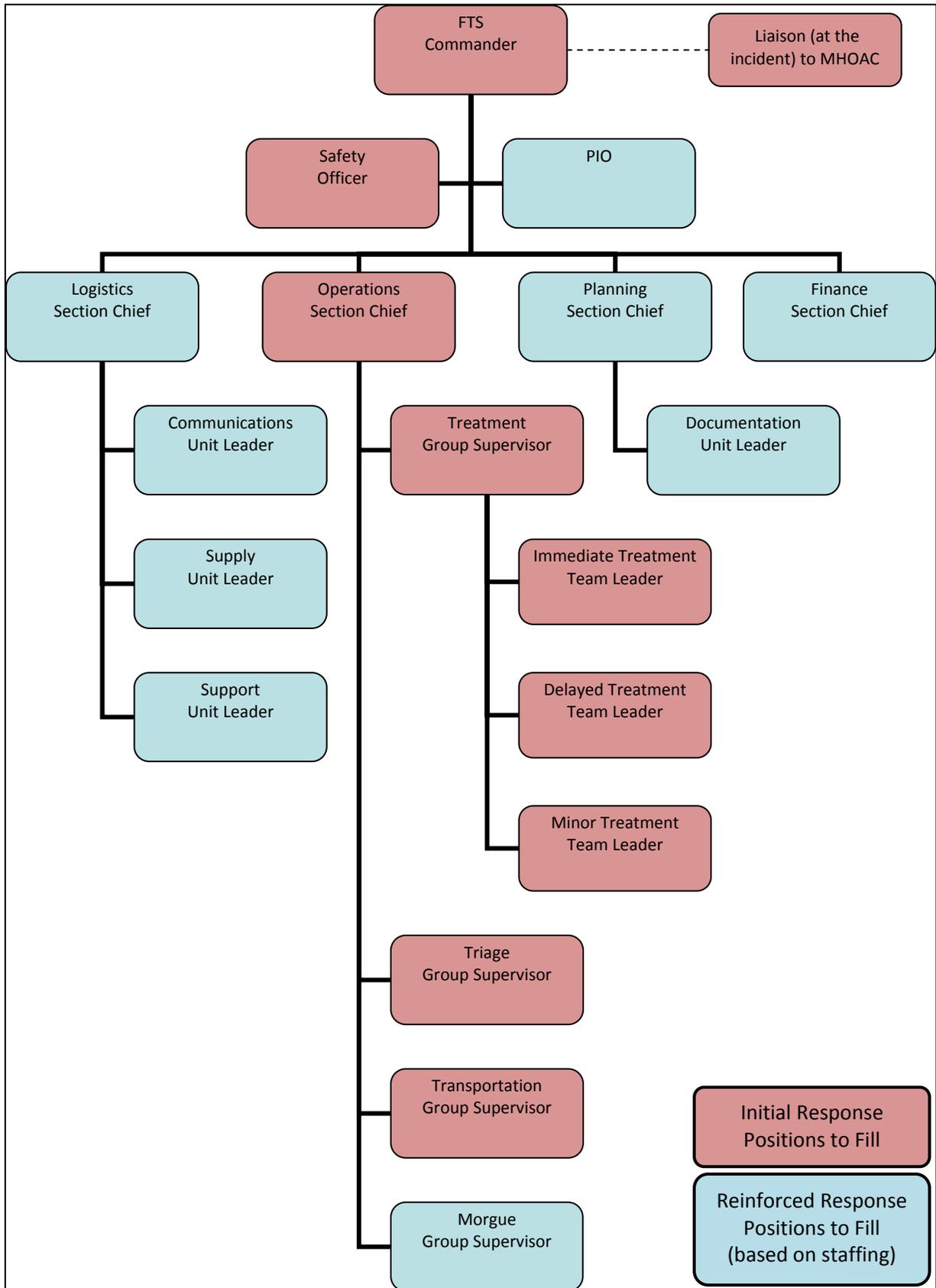
Site/Facility Map, Floor Plan, Photographs

Appendix 2: Sample Organizational Charts & Job Action Sheets/Descriptions

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



San Bernardino Model – considered minimum necessary to open FTS



JOB ACTION SHEET	MHOAC PROGRAM (Public Health or EMSDO)
FUNCTION:	Ensure FTS is established and maintain on-going communications with IC, MGS, FTS Commander, and DOC/EOC
AGENCY TO FILL JOB:	Public Health, EMS (ICEMA)
REPORT TO:	EOC Operations Section Chief or Unified Command
REPORTS TO YOU:	FTS Commander, MGS through liaison or designee
PRIMARY DUTIES:	Activation
	<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)
	Operations
	<input type="checkbox"/> Establish and maintain on-going communications between Scene IC, MGS, FTS Commander, DOC/EOC, ICEMA, and Region 6.

JOB ACTION SHEET		FTS COMMANDER
FUNCTION:		Ensure efficient operation of the FTS
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, EMS Nurse, Public Health appointee, Fire Command Staff
REPORT TO:		MHOAC, EOC
REPORTS TO YOU:		Safety Officer
		Public Information Officer (PIO)
		Operations Section Chief
		Logistics Section Chief
		Planning Section Chief
		Finance Section Chief
PRIMARY DUTIES:		Activation
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)
		Operations
		<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

JOB ACTION SHEET		SAFETY OFFICER
FUNCTION:		Ensure safe operations for staff and patients
AGENCY TO FILL JOB:		Fire or Law Enforcement, senior personnel
REPORT TO:		FTS Commander
REPORTS TO YOU:		Assistant Safety Officer(s), if any
PRIMARY DUTIES:		Activation
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

JOB ACTION SHEET	PUBLIC INFORMATION OFFICER (PIO)
FUNCTION:	Ensure adequate and appropriate information is shared with the media, public, and family members
AGENCY TO FILL JOB:	Public Health PIO, Health Officer, EMS Senior Leadership, Fire or Law PIO
REPORT TO:	FTS Commander
REPORTS TO YOU:	Assistant PIO(s), if any
PRIMARY DUTIES:	Activation
	<input type="checkbox"/> Prepares information for the public regarding the FTS location and care available
	<input type="checkbox"/> Coordinates 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

JOB ACTION SHEET		OPERATIONS SECTION CHIEF
FUNCTION:		Direct and supervise of medical triage, patient areas, and transportation
AGENCY TO FILL JOB:		EMS Specialist, EMS Nurse, Public Health Designee, Fire Command Staff
REPORT TO:		FTS Commander
REPORTS TO YOU:		Triage Unit Leader
		Treatment Unit Leader
		Transportation Unit Leader
		Medical Group Supervisor, if appointed
PRIMARY DUTIES:		Operations
Appendix	1	<input type="checkbox"/> Using the site layout diagram, identify and supervise:
		<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
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
SECONDARY DUTIES:		<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

JOB ACTION SHEET		LOGISTICS SECTION CHIEF
FUNCTION:		Responsible for operational functionality of the site; provide supplies, equipment, staffing, and support of operations as needed
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, EMS Nurse, Public Health Designee, Fire Command Staff
REPORT TO:		FTS Commander
REPORTS TO YOU:		Communications Unit Leader
		Supply Unit Leader
		Support Unit Leader
PRIMARY DUTIES:		Operations
		<input type="checkbox"/> Identify what medical resources are on scene
		<input type="checkbox"/> Identify what medical resources have been requested
Appendix	3	<input type="checkbox"/> Identify what additional medical resources are necessary and make official request (use appendix 3: 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 DOC; provide radio training as needed; consider requesting assistance through DOC 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
SECONDARY DUTIES:		Demobilization
		<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

JOB ACTION SHEET		PLANNING SECTION CHIEF
FUNCTION:		Document the event especially patient tracking, oversee and assign personnel, and support demobilization of FTS
AGENCY TO FILL JOB: (1st & 2nd Choice)		EMS Specialist, EMS Nurse, Public Health Designee, Fire Command Staff
REPORT TO:		FTS Commander
REPORTS TO YOU:		Documentation Unit Leader
PRIMARY DUTIES:		Operations
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	4	<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
SECONDARY DUTIES:		Demobilization
		<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 (ICEMA)
		<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

JOB ACTION SHEET		FINANCE SECTION CHIEF
FUNCTION:		Track staff time on-site and ensure patient records tracking and security as per HIPAA
AGENCY TO FILL JOB: (1st & 2nd Choice)		HHS Finance Department
REPORT TO:		FTS Commander
REPORTS TO YOU:		
PRIMARY DUTIES:		Operations
		<input type="checkbox"/> Track staff time on-site and ensure patient records tracking and security as per HIPAA
SECONDARY DUTIES:		Demobilization
		<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
Logistics Section			
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. Requests volunteers, traffic control supplies as necessary.</p>	1 -2 per shift	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Logistics Section/ Service Branch			
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 (Comm Center).	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	
Operations Section			
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)	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
Treatment Group Supervisor/Team	<p>Treatment Group Supervisor and Minor Treatment Team Leader, Immediate Treatment Team Leader and Delayed Treatment Team Leader and Teams.</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 Patient Inquiry Team Leader 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)	
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	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
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 Air Operations Controller (Team Leader) manages traffic flow within the helicopter landing area, assures patient and personnel safety, heliport area maintenance, and appropriate placement of heliport markings. The Ground Operations Controller (Team Leader) manages traffic flow of arriving and departing ambulances and other means of ground transportation. Medical Monitoring Team Leader (paramedic, preferably supervisor) and Teams 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.	
Plans Section	If required. Supervises Situation, Documentation, Resources, and Demobilization Units.	1 per shift.	
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.	

Position	Job Description	Cal EMSA Guidelines (+ 1 Backup)	Agency/Department Able to Provide Staff
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 and Map

California EMSA Recommended Supplies for FTS		Quantity per San Bernardino County Trailer (# of trailers)		Notes
Item	Qty/50 Patients	per trailer	# trailers	
Medications				
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			
Bandages and Dressings				
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 sheet, major	1 case, 6/case			
Burn sheet, minor	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 San Bernardino County Trailer (# of trailers)		Notes
Item	Qty/50 Patients	per trailer	# trailers	
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			
Non-Disposable Medical Supplies				
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			
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 San Bernardino County Trailer (# of trailers)		Notes
Item	Qty/50 Patients	per trailer	# trailers	
IV Sets, Needles and Syringes				
Blood administration set, "Blood Y"	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			
Immobilization Supplies				
Collar, extrication, non-absorbing, adult (stores flat)	30 each			
Collar, extrication, non-absorbing, pediatric (stores flat)	10 each			
C Spine Head Immobilizer	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 San Bernardino County Trailer (# of trailers)		Notes
Item	Qty/50 Patients	per trailer	# trailers	
Splint, traction, femur, pediatric	1 each			
Miscellaneous Medical Supplies				
Airways, Supraglottic Airway	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			
BVM, 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 (Peds/ Adult)	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, or bags	1 carton, 10/carton			
Endotracheal tubes, French 2 sizes	2 each (2 of each size)			

California EMSA Recommended Supplies for FTS		Quantity per San Bernardino County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Combitube (all sizes)	2 each			
Face masks, disposable, combination use	25 each			
Face masks, disposable, combination use	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),	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			
Towels, paper, rolls	1 case, 12/case			

California EMSA Recommended Supplies for FTS		Quantity per San Bernardino County Trailer (# of trailers)		
Item	Qty/50 Patients	per trailer	# trailers	Notes
Urinals with lids, male, disposable	1 case, 50/case			
Urinals, female, disposable	5 cases, 10/case			
Water purification tabs	1 bottle			

Need to insert map containing:

- Major highways
- Main towns
- Location of trailers
- Location of Hospitals
- Location of pre-designated FTSs
- Pictures of pre-designated FTSs

Appendix 4: FTS and ICS Forms

Additional useful forms may include:

ICS Forms, available at

http://www.fema.gov/pdf/emergency/nims/ics_forms_2010.pdf

or refer to

San Bernardino County Emergency Operations Plan

And

California Public Health and Medical
Emergency Operations Manual (EOM)

Available at:

www.bepreparedcalifornia.ca.gov

including:

Health and Medical Situation Report (SITREP) as Appendix 6

and

Resource Request: Health and Medical – out of OA as Appendix 7

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. .

Date:	Time:	Site:	Person Reporting:
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Shift (Time Period Covered By This Report):

Phone #	Fax #
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# Patients Triage:	Current	Day Total	# Patients Minor Injury (GREEN) - Treated and Released:	Current	Day Total
# Patients in Delayed (YELLOW):	Current	Day Total	# Patients in Immediate (RED)	Current	Day Total
# Patients Transported to Hospital or Other	Current	Day Total	# Patients Deceased	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		
Position	Telephone # or Radio Available	To Communicate With
Communications Unit Leader		ALL
Transportation Group Supervisor		ALL
Air Operations Controller		Helicopters
Ground Operations Controller		Ambulances
Transportation Control Officer		Hospitals and/or ACSs, MHOAC, EMS DOC (ICEMA)
Resources Unit Leader		EMS, PH DOC, EOC, Hospitals, vendors, other jurisdictions, MHOAC
Site Incident Commander		EMS, PH DOC, EOC, MHOAC
Safety Officer		Law Enforcement
Public Information Officer		EMS, PH DOC PIO, OA EOC PIO (JIC), media
Medical Unit Leader		Hospitals, EMS, PH DOC, EOC, MHOAC
Situation Unit Leader		EMS, PH DOC, EOC, MHOAC
Morgue Group Supervisor		Coroner/Medical Examiner Office

FTS ON-SITE TRAINING					
Orientation/ Training Subject	Command Staff	Support Branch	Service Branch	Operations Section	Plans Section
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:			

Appendix 5: Acronyms

AAR	After-Action Report
ACS	Alternate Care Site
AC	Air Conditioning
ADA	American Disabilities Act
AED	Automated External Defibrillator
ALS	Advanced Life Support
BLS	Basic Life Support
Cal-MAT	California Medical Assistance Team (state resource)
CISD	Critical Incident Stress Debriefing
DHV	Disaster Healthcare Volunteer
DMAT	Disaster Medical Assistance Team (federal resource)
DOC	Department Operations Center
DWP	Department of Water and Power (Los Angeles)
EMCC	Emergency Medical Care Committee
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EMSDO	Emergency Medical Services Duty Officer
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOM	California Public Health and Medical Emergency Operations Manual
EOP	Emergency Operations Plan
FTS	Field Treatment Site
HIPAA	Health Insurance Portability and Accountability Act
HVAC	Heating, Ventilation, and Air Conditioning
IAP	Incident Action Plan
IC	Incident Commander
IP	Improvement Plan
ICEMA	Inland Counties Emergency Medical Agency
ICS	Incident Command System
JIC	Joint Information Center
LEMSA	Local Emergency Medical Services Agency
MCI	Multi-Casualty Incident
MGS	Medical Group Supervisor
MHOAC	Medical Health Operational Area Coordinator **
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
OA	Operational Area
PA	Public Address
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Dispensing
PPE	Personal Protective Equipment
RACES	Radio Amateur Civil Emergency Service
REOC	Regional Emergency Operations Center
SCE	Southern California Edison
SEMS	Standardized Emergency Management System
SITREP	Situation Report
SO	Sheriff's Office
START	Simple Triage and Rapid Treatment
TDD	Telecommunications Device for the Deaf
Wi-Fi	Trademark name for a wireless Internet access point

** The MHOAC in San Bernardino County is a program not an individual.



Inland Counties Emergency Medical Agency

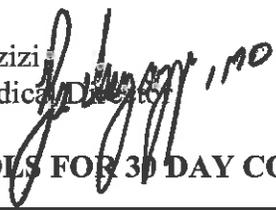
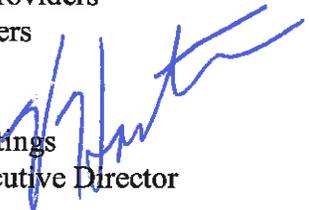
Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director

Reza Vaezazizi, M.D., Medical Director

DATE: December 14, 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, ICEMA Medical Director  Virginia Hastings, ICEMA Executive Director 

SUBJECT: PROTOCOLS FOR 30 DAY COMMENT

The following 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 will be 30 days as per ICEMA Protocol #5030.

ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until Friday January 13, 2012 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to SShimshy@cao.sbcounty.gov. Comments submitted and any revisions made will be presented at the January 2012 Emergency Medical Care Committee (EMCC) meetings held in all three counties.

Protocol

Reference #:

- Draft Minimum Documentation Requirements for Transfer of Patient Care
- Draft ICEMA Abbreviation List
- 7010 BLS/ALS Standard Drug and Equipment List
- 7020 EMS Aircraft Standard Drug and Equipment List

RV/VH/DWS/SS/mae

Attachments: 4



ICEMA ABBREVIATION LIST

PURPOSE:

To provide uniform documentation and universal understanding of approved abbreviations.

Authority:

Health and Safety Code
EMCC AD Hoc Committee

Requirements:

All EMS providers will only use ICEMA approved abbreviations provided on this list to prevent confusion on documentation.

List the abbreviations and definitions.

abdomen, abdominal	abd
abdominal aortic aneurysm	AAA
acquired immune deficiency syndrome	AIDS
acute myocardial infarction	AMI
advanced life support	ALS
against medical advice	AMA
airway, breathing, circulation	ABC
appearance, pulse, grimace, activity, respiration	APGAR
as soon as possible	ASAP; asap
aspirin	ASA
At	@
atrial fibrillation	A-fib; afib
atrial flutter	A-flutter
atrial tachycardia	A-Tach

Automated External Defibrillator	AED
bag valve mask	BVM
Basic Life Support	BLS
blood pressure	BP
bowel movement	BM
bundle branch block	BBB
by mouth	PO; p.o.
carbon dioxide	CO2
cardiopulmonary resuscitation	CPR
cerebrovascular accident	CVA
Chest pain	CP
chief complaint	CC; C/C
chronic obstructive pulmonary disease	COPD
complains of	C/O; c/o
congestive heart failure	CHF
continuous positive airway pressure	CPAP
coronary artery disease	CAD
date of birth	DOB
dead on arrival	DOA
diagnosis	Dx
do not resuscitate	DNR
electrocardiogram	ECG; EKG
emergency department	ED
Emergency Medical Services	EMS
Emergency medical technician	EMT
Emergency medical technician-paramedic	EMT-P
emergency room	E.R.
emergency department	E.D.
endotracheal tube	ET
Estimated Time of Arrival	ETA: eta
fracture	Fx: fx

gram	gm
gunshot wound	GSW
history	Hx
hypertension	Htn; HTN
intensive care unit	ICU
intramuscular	IM
intravenous	IV
Intravenous push	IVP
jugular venous distension	JVD
kilograms	kg
laceration	LAC
last menstrual period	LMP
left lower quadrant of abd	LLQ
Level or loss of consciousness	LOC, loc, KO
liter	L
milligram(s)	mg
milliliter	ml
minute(s)	min.
myocardial infarction	MI
nasal cannula	nc
negative	neg.
nitroglycerin	Nitro or NTG
No known allergies	NKA
obstetrics	OB
oxygen	O2
Oxygen Saturation	O2 sat
paroxysmal supraventricular tachycardia	PSVT
patient	Pt; pt
pound	lb; #
premature ventricular contraction	PVC
prescription; intervention plan; therapy	Rx

prior to (our) arrival	PTOA; PTA
Privately owned vehicle	POV
psychiatric	psych
pupils equal reactive to light	PERL, PEARL, or PERRLA
right	R
right lower quadrant of abd	RLQ
short(ness) of breath	SOB
Sinus Bradycardia	SB, S-Brady
Sinus Tachycardia	ST, S-Tach
subcutaneous	sc; subQ
sublingual	SL
to keep open	TKO
transient ischemic attack	TIA
tuberculosis	TB
urinary tract infection	UTI
vital signs	v.s
within normal limits	WNL; wnl
Wolf-Parkinson-White	WPW
year	yr
years old	Y/O; y.o.
above knee amputation	AKA
Below knee amputation	BKA
Advanced Cardiac Life Support	ACLS
after surgery	Post op
Alcohol Intoxication	ETOH
alert & oriented to (person, place, time & event)	A & O x of 4
alert, verbal, pain. unresponsive	AVPU
Altered level of consciousness	ALOC
ampule	amp
anterior	ant
arterial blood gas	ABG
Base Station	Base

beats per minute	bpm
Body Surface Area	BSA
cancer, carcinoma	CA
cerebral spinal fluid	CSF
Cervical collar	C-collar
Cervical spine	C-spine
dextrose solution	D50 50%
discontinue or discharged	DC; D/C; dc
drops	gtts
epinephrine	EPI
Estimated blood loss	EBL
evaluation	eval.
Evening	pm
foreign body	fb
gastrointestinal	GI
Glasgow Coma Scale	GCS
heart rate	HR
hour	h; hr
human immunodeficiency virus	HIV
intraosseous	IO
Intravenously	IV
Landing Zone	LZ
lateral	Lat
left	L; Lt
left bundle branch block	LBBB
left upper quadrant of abd	LUQ
loss/level of consciousness (as noted by context)	LOC
maximum	max
medical doctor	M.D.
Miles per hour	mph

milliequivalents	mEq
morning	a.m.
motor vehicle accident	MVA
Multiple Casualty Incident	MCI
multiple sclerosis,	MS
morphine sulfate	
nausea/vomiting	n/v
nausea/vomiting/diarrhea	n/v/d
normal sinus rhythm	NSR
not applicable	N/A
nothing by mouth	NPO
onset, provocation, quality, radiation, severity, time	OPQRST
overdose	OD
past medical history	PMH
pediatric	ped
posterior	post
pulse, motor, sensation	PMS
Pulse, motor, sensory, cap refill	PMSC
Rehabilitation	rehab
right bundle branch block	RBBB
second(s)	sec.
supraventricular tachycardia	SVT
Traffic collision	TC
ventricular fibrillation	V-Fib or VF
ventricular tachycardia	V-Tach or VT
versus	vs
weight	wt
whenever necessary, as needed	prn
acute renal failure	ARF
admission, admitted	adm
adult respiratory distress syndrome	ARDS

amount	amt
Apparent Life Threatening Event	ALTE
Appointment	appt
approximate	approx
auscultation	ausc
Automatic Implanted Cardiac Defibrillator	AICD
Bag of waters	BOW
Base Station Order	BSO
bilateral	Bilat
calcium	Ca
carbon monoxide	CO
Centimeter	cm
central nervous system	CNS
circulation, motor and sensation	CMS
Clear bi-lateral	CBL
complete blood count	CBC
coronary artery bypass graft	CABG
Defibrillation	Defib
delirium tremor	DT
Dextrose 25% (diluted D50)	D25
dextrose in water	D5W 5%
Did not obtain/Did not order	DNO
Difficulty breathing	Diff Breath
ethanol (alcohol)	ETOH
every	q
female	f
gynecology	GYN
height	ht.
history of	h/o

Hydrochlorothiazide	HCTZ
inch	in.
Incident Commander	IC
intracranial pressure	ICP
Intravenous piggy back	IVPB
irregular	irreg
joules	J
Left lower quadrant	LLQ
mechanism of injury	MOI
microgram(s)	mcg
military anti-shock trousers	MAST
Mobile intensive care nurse	MICN
month, months old	mo; m/o
Nasogastric (tube)	NG
No Acute Distress	NAD
No known drug allergies	NKDA
Non Steroidal Anti-inflammatory Drugs	NSAIDS
normal saline	NS
Para, number of pregnancies	P
Paramedic	Medic
Passenger space intrusion	PSI
Pediatric Advanced Life Support	PALS
pelvic inflammatory disease	PID
physical exam, pulmonary embolism, pedal edema (as noted by context)	PE
post, after	p
Pregnancy Induced Hypertension	PIH
premature atrial contraction	PAC
premature junctional contraction	PJC

pulseless electrical activity	PEA
range of motion	ROM
registered nurse	RN
rule out	R/O; r/o
Saline Lock	SL
sexually transmitted disease	STD
signs and symptoms	S/S; s/s
signs, symptoms, allergies medications, past history, last intake, events	SAMPLE
Strong and regular	S&R
sudden infant death syndrome	SIDS
transport	trans
Unable to locate	UTL
Unknown	unk
water	H2O
white blood cell (count)	WBC
with	c
without	s
abduction	Abd;abd
above knee	AK
active range of motion	AROM
activities of daily living	ADL
ambulate, ambulating, ambulated, etc.	amb
and	&
Antecubital	AC
arteriosclerotic heart disease	ASHD

Atherosclerotic heart disease	ASHD
Attention Deficit Hyperactivity Disorder	ADHD
below knee amputation	BKA
bicarbonate, NaCO ₃	bicarb
blood alcohol content	BAC
breath/bowel sounds	BS; b.s.
Calcium Chloride	CACL
cervical immobilization device	CID
computerized axial tomography	CAT
conscious, alert & oriented to person, place, time and event	CAOx4
continue, continuous	cont.
days old	d/o
deep vein thrombosis	DVT
department	dept
diabetes mellitus	DM
Dilation and curettage	D&C
dyspnea on exertion	DOE
electroencephalogram	EEG
Equal	=
Esophageal Tracheal Airway Device	ETAD
et cetera	etc
extension	ext.
eyes, ears, nose, throat	EENT
fire department	FD
flexion	flex
foot, feet (not anatomy)	ft.
full range of motion	FRom
gallbladder	GB

Grain	Gr
Gravida 1,2,3 etc.	
Greater than or equal to	
head, eyes, ears, nose, throat	HEENT
headache	HA; H/A
hematocrit	Hct
hemoglobin	Hb; hgb
history & physical	H&P
immediately	stat
infant respiratory distress syndrome	IRDS
inferior	inf
intake (input) & output	I&O
Intrauterine Device	IUD
Kilometer	Km
Labor and delivery	L&D
Laboratory	Lab
Last normal menstrual period	LMP
Left lower extremity	LLE
Left lower lobe	LLL
Left upper extremity	LUE
left upper lobe of lung	LUL
Less than	
licensed practical nurse	LPN
Lidocaine	Lido
liter per minute	lpm, l/m
long back board	LBB
lumbar puncture	LP
lung sounds	L/S
Magnesium Sulfate	Mag
medications	meds
mercury	Hg
millidrops, microdrops	mggt
millimeter	mm
millivolt	mv

minimal	min
mobile intensive care unit	MICU
moderate	mod
Motor Vehicle Accident (Multi-Victim Accident)	MVA
Narcotic	NARC
nasogastric	NG; ng
Non rebreather mask	NRB
occupational therapist/therapy	OT
operating room	OR
Orogastric (tube)	OG
ounce	oz.
Palpable	palp
Paroxysmal Nocturnal Dyspnea	PAT
past history	P.H.; PHx
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
physician's assistant	P.A.
police department	PD
positive	pos.
possible	poss
potassium	K
Potassium Chloride	KCL
quart	qt.
red blood cell (count)	RBC
regarding	re:
respiration, respiratory	resp
respiratory rate	RR
Respiratory Therapist	RT
response	RESPS
rheumatoid arthritis	RA
Right lower extremity	RLE
right upper lobe of lung	RUL
right upper quadrant of abd	RUQ



MINIMUM DOCUMENTATION REQUIREMENTS FOR TRANSFER OF PATIENT CARE

PURPOSE:

To define the minimum amount of fields on a patient care record that must be completed prior to the transfer of care between pre-hospital providers if available, applicable or known.

AUTHORITY:

Title 22, Division 9, Chapter 4, Article 8, §100170
EMCC AD HOC Committee

PROCEDURE:

First responders must complete the following mandatory fields prior to transferring care of a patient to a transporting agency whether using paper or electronic documentation.

- 1) Patient identifier
 - a. Name
 - b. Sex
 - c. Birth date

- 2) Chief complaint.
- 3) Mechanism of injury
- 4) Time of onset/ last seen normal
- 5) Pertinent medical history
 - a. Medications
 - b. Allergies
- 6) Vital signs
 - a. Blood pressure
 - b. Pulse rate and quality
 - c. Respiration rate and quality
 - d. Skin signs

- 7) Glasgow Coma Scale
- 8) PQRST for pain.
- 9) All 12 Lead ECG with patient name will accompany the patient
- 10) All medications, and procedures including attempts with times done prior to transfer

- 11) If base station contact made document which base station contacted
- 12) First responder unit identifier.
- 13) Transport unit identifier
- 14) Any other pertinent information not seen by the transport agency that might affect patient care.

The narrative should be written if there is time or shall be given verbally to the next provider. Other fields should be completed if possible or if the fields pertain to the chief complaint.

In the event of a MCI the minimum mandatory documentation required are the triage tags. All patients in an MCI regardless of the degree of injury or lack of injury must have a triage tag.



BLS/ALS STANDARD DRUG & EQUIPMENT LIST

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

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

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS	ALS Non-Transport	ALS Transport
Activated Charcoal 25 gm		2	2
Adenosine (Adenocard) 6 mg		1	1
Adenosine (Adenocard) 12 mg		2	2
Adrenaline (Epinephrine) 1:1000 1 mg		2	2
Adrenaline (Epinephrine) 1:10,000 1 mg preload		3	3
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg		4 doses	4 doses
Aspirin, chewable – 81mg tablet		1 bottle	1 bottle
Atropine 1 mg preload		4	4
Calcium Chloride 1 gm preload		1	1
Dextrose 25% 2.5 gm preload		2	2
Dextrose 50% 25 gm preload		2	2
Diphenhydramine (Benadryl) 50 mg		1	1
Dopamine 400 mg		1	1
Glucagon 1 mg		1	1
Glucose paste	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg		4	4
Irrigating Saline and/or Sterile Water (1000cc)	2	1	2
Lidocaine 100 mg		3	3
Lidocaine 1gm or 1 bag pre-mixed 1gm/250cc D5W		1	1
Lidocaine 2% (Viscous) bottle		1	1
Magnesium Sulfate 10 gm		1	1
Naloxone (Narcan) 2 mg preload (needle less)		2	2
Nitroglycerine – Spray 0.4mg metered dose <u>and/or tablets (tablets to be discarded 90 days after opening)</u>		1	2
Normal Saline for Injection (10cc)		2	2

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

CONTROLLED SUBSTANCE MEDICATIONS

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

AIRWAY/SUCTION EQUIPMENT

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

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

Non-Exchange Airway/Suction Equipment	BLS	ALS Non-Transport	ALS Transport
Ambulance Oxygen source –10L/min for 20 minutes	1		1
Flashlight/penlight	1	1	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight		1 each	1 each
Laryngoscope handle with batteries – or 2 disposable handles		1	1
Magill Forceps – Pediatric and Adult		1 each	1 each
Portable Oxygen with regulator – 10L/min for 20 minutes	1	1	1
Portable suction device (battery operated)	1	1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1
Stethoscope	1	1	1
Wall mount suction device	1		1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

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

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

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

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	ALS Non-Transport	ALS Transport
AED/defib pads	2		
Ammonia Inhalants		2	2
Approved Automatic ventilator		1	1
Backboard padding	1	1	1

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

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

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

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



EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

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

MEDICATIONS/SOLUTIONS

Medications/Solutions	Amount
Activated Charcoal 25 gm	2
Adenosine (Adenocard) 6mg	30mg
Adrenaline (Epinephrine) 1:1,000	2mg
Adrenaline (Epinephrine) 1:10,000	3mg
Albuterol Aerosolized Solution (Proventil)-unit dose 2.5mg	2 doses
Aspirin, chewable - 81mg tablet	1bottle
Atropine 1mg preload	3mg
Calcium Chloride	1gm
Dextrose 25%	50gm
Dextrose 50%	50gm
Diphenhydramine (Benadryl) 50mg	50mg
Furosemide (Lasix)	40mg
Glucagon	1mg
Intropin (Dopamine)	200mg
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Lidocaine	300mg
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250cc D5W	2gm
Lidocaine 2% (Viscous)	2oz
Magnesium Sulfate 10mg	10gms
Naloxone (Narcan)	10mg
Nitroglycerin – Spray 0.4 mg metered dose <u>and/or tablets (tablets to be discarded 90 days after opening.)</u>	1
Normal Saline for Injection (10cc)	2
Normal Saline 250ml	1
Normal Saline 1000ml	4
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5mg per metered dose	1bottle
Procainamide	1gm

Medications/Solutions	Amount
Sodium Bicarbonate	100mEq
Verapamil (Isoptin)	15mg

CONTROLLED SUBSTANCE MEDICATIONS

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

AIRWAY/SUCTION EQUIPMENT

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

OPTIONAL EQUIPMENT/MEDICATIONS

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

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

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

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