POLICY, PROCEDURE AND PROTOCOL MANUAL

The enclosed policies, procedures, and protocols are effective August 8, 2017. The original signatures for these are on file at ICEMA and available upon request.

August 8, 2017

Tom Lynch, EMS Administrator

August 8, 2017

Reza Vaezazizi, MD, Medical Director

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EMT CERTIFICATION

I. PURPOSE

To define requirements for certification/recertification of an eligible applicant as an Emergency Medical Technician (EMT) recognized in the State of California.

II. ELIGIBILITY

To be eligible for initial certification, an applicant shall meet the following requirements:

1. Be eighteen (18) years of age or older.

2. Complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan) prior to application for certification.

3. Meet one of the following criteria:

    a. Pass the National Registry of Emergency Medical Technicians (NREMT) - EMT written and skills examination, possess a current and valid NREMT - EMT card and documentation of successful completion of an initial EMT course (California or out-of-state) within two (2) years of the date of application, or

    b. Pass the NREMT - EMT written and skills examination within two (2) years from the date of application for EMT certification and possess a current and valid out-of-state EMT certificate, or

    c. Possess a current and valid NREMT - EMT, Advanced EMT (AEMT), or Paramedic (EMT-P) certificate, or

    d. Possess a valid out-of-state AEMT or EMT-P certificate, or

    e. Possess a current and valid California AEMT or a current and valid California EMT-P license.

NOTE: *An EMT shall only be certified by one (1) certifying entity during a certification period.*

III. PROCEDURES

Initial Certification

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes:

   a. A copy of a valid government issued photo identification.

   b. A copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent.

   c. A copy of completed Live Scan form.

   d. A copy of a valid certification as listed in Section II, Item 3 above.

   e. Disclose any prior and/or current certification, licensure, or accreditation actions:

      (1) Against an EMT, or AEMT certificate, or any denial of certification by a LEMSA, including any active investigations;

      (2) Against a EMT-P license, or any denial of licensure by the authority, including any active investigation;

      (3) Against any EMS related certification or license of another state or other issuing entities, including denial and any active investigations, or

      (4) Against any health-related license.

   f. Disclose any pending or current criminal investigations.

   g. Disclose any prior convictions.

   h. Disclose each certifying entity or LEMSA to which the applicant has applied for certification in the previous twelve (12) months.

2. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

3. The EMT shall be responsible for notifying the certifying entity of her/his proper and current mailing address and shall notify the certifying entity in writing within thirty (30) calendar days of any changes of the mailing address, giving both the old and the new address, and EMT registry number. This

notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net.

4. The EMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.

5. Comply with other requirements as may be set forth herein.

Effective Dates

The effective date of initial certification shall be the day the certificate is issued. The expiration date for an initial EMT certificate shall be the last day of the month two (2) years from the effective date of the initial certification.

Recertification

To recertify as an EMT, an applicant shall:

1. Possess a current EMT certification issued in California.

2. Meet one (1) of the following continuing education (CE) requirements:

   a. Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program within the twenty-four (24) months prior to applying for renewal, or

   b. Obtain at least twenty-four (24) hours of CE, with in the twenty-four (24) months prior to applying for renewal, from an approved CE provider.

3 Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes the requirements listed in Section III, Item 1(a - h) above.

4. Complete the criminal history background check requirements when changing certifying entities. Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan).

5. Copy of completed skills competency verification form, EMSA-SCV (01/17).

   Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competence shall be verified by an individual who is currently certified or licensed as an EMT, AEMT, EMT-P, Registered Nurse, Physician's Assistant, or Physician and who shall be designated by an EMS approved training program, or an EMS service provider. Verification of skills competence shall be valid for a maximum of two (2) years for the purpose of applying for recertification.

6. Starting July 1, 2019, EMTs renewing their certification for the first time shall submit documentation of successful completion of the following training at an approved EMT training program or approved CE provider:

   a. The use and administration of naloxone or other opioid antagonist.

   b. The use and administration of epinephrine by auto-injector.

   c. The use of a glucometer.

7. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

   NOTE: *If the applicant is not currently an ICEMA certified EMT, the EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

8. The EMT shall be responsible for notifying the certifying entity of her/his proper and current mailing address and shall notify the certifying entity in writing within thirty (30) calendar days of all changes of the mailing address, giving both the old and the new address, and EMT registry number. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net.

Expiration While Deployed for Active Duty

A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States, shall have six (6) months from the date they return from active duty deployment to complete requirements for recertification noted above.

In order to qualify for this exception, the applicant shall:

1. Submit proof of his or her membership in the Armed Forces of the United States, and

2. Submit documentation of his or her deployment starting and ending dates.

3. CE credit may be given for documented training that meets the requirements of Chapter 11 of the California Code of Regulations, Title 22, Division 9.

4. The CE documentation shall include verification from the individual's Commanding Officer attesting to the training attended.

Effective Dates

1. If the EMT renewal requirements are met within six (6) months prior to the expiration date, the effective date of renewal shall be the date immediately following the expiration date of the current certificate. The certification expiration date will be the last day of the month, two (2) years from the effective date.

2. If requirements are met more than six (6) months prior to the expiration date, the effective date of renewal shall be the date the applicant satisfactorily completes all renewal requirements and has applied for certification. The certification expiration date will be the last day of the month two (2) years from the effective date.

Reinstatement of an Expired California EMT Certificate

The following requirements apply to applicants who wish to be eligible for reinstatement after their California EMT certificates have expired:

1. Lapse of less than six (6) months the applicant must complete all requirements in Section III, Items 2 - 7 under Recertification above.

2. Lapse of six (6) months or more, but less than twelve (12) months:

    a. Complete all requirements in Section III, Items 2 - 7 under Recertification above.

    b. Complete one (1) of the following CE requirements:

        (1) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program, and twelve (12) hours of CE, within the twenty-four (24) months prior to applying for reinstatement, or

        (2) Obtain at least thirty-six (36) hours of CE, within the twenty-four (24) months prior to applying for reinstatement, from an approved CE provider.

2. Lapse of twelve (12) months or more, but less than twenty-four (24) months:

    a. Complete all requirements in Section III, Items 2 - 7 under Recertification above.

    b. Complete one (1) of the following continuing education requirements:

        (1) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program, and twenty-

four (24) hours of CE, within the twenty-four (24) months prior to applying for reinstatement, or

(2) Obtain at least forty-eight (48) hours of CE, within the twenty-four (24) months prior to applying for reinstatement, from an approved CE provider.

c. Pass the National registry cognitive and psychomotor exams, within two (2) years of the date of application for EMT reinstatement unless the individual possess a current and valid EMT, AEMT, or EMT-P National Registry Certificate or a current and valid AEMT certificate or EMT-P license.

IV. REFERENCES

Number	Name
1090	Criminal History Background Checks (Live Scan)

EMR CERTIFICATION

I. PURPOSE

To define the requirements for certification/recertification of eligible individuals, who voluntarily request certification as an Emergency Medical Responder (EMR) by the ICEMA Medical Director.

II. ELIGIBILITY

In order to be eligible to apply for certification as an EMR an individual at the time of application must:

1. Be a minimum of eighteen (18) years of age.

2. Possess a course completion record and apply for certification within six (6) months of course completion.

III. PROCEDURE

Initial Certification

An individual applying for initial certification as an EMR within the ICEMA region shall:

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes:

    a. Copy of a valid government issued photo identification.

    b. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

    c. Copy of course completion record.

2. Submit the established ICEMA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

3. The EMR shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at http://ICEMA.net.

4. Comply with other requirements as may be set forth herein.

Effective Dates

The expiration date shall be two (2) years from the date of successful passage of the EMR certifying examination.

Recertification

An individual applying for recertification as an EMR within the ICEMA region shall:

1. Apply for recertification within six (6) months of successful passage of the EMR recertifying examination.

2. Meet all recertification requirements within six (6) months prior to the expiration date of the current certificate; otherwise, the expiration date shall be two (2) years from the date of successful passage of the EMR recertifying examination.

3. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes:

    a. Copy of a valid government issued photo identification.

    b. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

    c. Copy of the certificate that qualifies the individual to apply for recertification as an EMR.

4. Submit the established ICEMA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

Effective Dates

The expiration date shall be two (2) years from the date of successful passage of the EMR certifying examination.

EMT-P ACCREDITATION

I. PURPOSE

To define the accreditation and reverification requirements for an eligible applicant to practice as an Emergency Medical Technician - Paramedic (EMT-P) within the ICEMA region.

II. ELIGIBILITY

1. Possess a current California EMT-P License.

2. Current employment as an EMT-P by an authorized Advance Life Support (ALS) service provider or by an EMS provider that has formally requested ALS authorization in the ICEMA region.

III. PROCEDURE

Accreditation/Reverification

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net that includes:

   a. Copy of a valid government issued photo identification.

   b. Copy of a valid California EMT-P license.

   c. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

   d. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

2. Submit the established ICEMA fee. Fees paid for accreditation are not refundable or transferable. ICEMA fees are published on the ICEMA website at ICEMA.net.

3. The EMT-P shall be responsible for notifying ICEMA of any and all changes in name, employer, e-mail and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net.

Note: *If ICEMA accreditation has lapsed for more than one (1) year, the applicant must comply with the initial accreditation procedure.*

Initial Accreditation

1. Pass the ICEMA EMT-P accreditation written examination with a minimum score of eighty percent (80%).

    a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a minimum passing score of eighty-five (85%).

    b. A candidate who fails to pass the ICEMA written examination on the second attempt will have to pay the established ICEMA fee, and provide documentation of eight (8) hours of remedial training in ICEMA protocols, policies/procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a minimum passing score of eighty-five (85%).

    c. If the candidate fails to pass the ICEMA written examination on the third attempt, the candidate will be ineligible for accreditation for a period of six (6) months, at which time candidate must reapply and successfully complete all initial accreditation requirements.

ICEMA accreditation will be effective from the date all requirements are verified and expire on the same date as the California EMT-P license, provided all requirements continue to be met.

MICN AUTHORIZATION - Base Hospital, Administrative, Flight Nurse, Critical Care Transport

I. PURPOSE

To define the requirements required for a Registered Nurse (RN) to obtain a Mobile Intensive Care Nurse (MICN) authorization within the ICEMA region.

II. DEFINITIONS

Advanced Life Support (ALS): Special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

Mobile Intensive Care Nurse (MICN): A Registered Nurse (RN) who has been deemed qualified and authorized by the ICEMA Medical Director to provide ALS services or to issue physician directed instructions to EMS field personnel within an Emergency Medical Services (EMS) system according to ICEMA developed standardized procedures and consistent with statewide guidelines.

Mobile Intensive Care Nurse - Base Hospital (MICN-BH): An ICEMA authorized MICN who is authorized as a MICN-BH to issue physician directed instructions to EMS field personnel while working for a recognized base hospital within the ICEMA region.

Mobile Intensive Care Nurse - Administrative (MICN-A): An ICEMA authorized MICN who works in an administrative/supervisory capacity for an approved ALS provider within the ICEMA.

Mobile Intensive Care Nurse - Flight (MICN-F): An ICEMA authorized MICN who has received additional training related to flight operations and is authorized to provide ALS services during flight operations aboard air ambulances and/or air rescue aircraft within the ICEMA region.

Mobile Intensive Care Nurse - Critical Care Transport (MICN-C): An ICEMA authorized MICN who has received additional training related to critical care transport and is authorized to provide ALS services during critical care ground transports by approved EMS providers.

III. POLICY

1. All RNs working in a capacity that will require them to provide ALS services or to issue physician directed instructions to prehospital emergency medical care personnel within the ICEMA region shall submit a completed application and meet criteria established by the ICEMA Medical Director.

2. All MICNs shall notify ICEMA of any and all changes in name, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net.

3. All MICNs shall notify ICEMA immediately of termination of their employment with an approved entity and/or employment by another ICEMA approved base hospital and/or non-base hospital employer. If employment with an approved EMS provider is terminated, the MICN authorization will be rescinded unless proof of other qualifying employment is received by ICEMA within thirty (30) days.

4. MICNs may hold authorization in multiple categories but must apply and submit all required documentation. MICN authorization may be added to or converted to another MICN category by meeting all requirements for authorization in that category.

IV. PROCEDURE

General Procedures for MICN Authorization/Reauthorization

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net for each MICN category applied for that includes:

    a. Copy of a valid government issued photo identification.

    b. Copy of a valid California RN license.

    c. Proof of completion of an ICEMA approved MICN course with a passing score of at least eighty percent (80%). (MICN-BH Initial Authorization Only)

    d. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

e. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

2. Submit the established ICEMA fee. Additional categories may be applied for without additional fee. Authorization cards issued within six (6) months of nursing license expiration is exempt from reauthorization fee. Fees paid for authorization are not refundable or transferable. ICEMA fees are published on the ICEMA website at ICEMA.net.

MICN-BH Authorization by Challenge

1. Meet one (1) of the following eligibility requirements:

   a. MICN in another county if approved by the ICEMA Medical Director.

   b. An eligible RN who has been a MICN in ICEMA region who has let authorization lapse longer than six (6) months.

ICEMA authorization will be effective from the date all requirements are verified and expire on the same date as the California RN license, provided all requirements continue to be met.

CERTIFICATION/ACCREDITATION REVIEW POLICY

I. PURPOSE

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

II. POLICY

1. Disciplinary proceedings are in accordance with California Code of Regulations, Title 22, Chapter 6.

2. Licensure and certification actions (e.g., immediate suspension) shall be performed according to the California Health and Safety Code, Section 1798.202.

3. If the action is to recommend to the EMS Authority for disciplinary action of an EMT-P license:

    a. A summary explaining the actions of the EMT-P that are a threat to the public health and safety pursuant to the California Health and Safety Code, Section 1798.200; and,

    b. Documented evidence, relative to the recommendation, collected by the Medical Director, forwarded to the EMS Authority.

4. Request for discovery, petitions to compel discovery, evidence and affidavits shall be followed pursuant to the Administrative Procedures Act (Government Code, Title 2, Chapter 5, Sections 11507.6, 11507.7, 11513, and 11514).

EMT/AEMT INCIDENT INVESTIGATION, DETERMINATION OF ACTION, NOTIFICATION, AND ADMINISTRATIVE HEARING PROCESS

I. PURPOSE

To establish a policy and procedure governing reportable situations and the evaluation and determination regarding whether or not disciplinary cause exists.

II. POLICY

Any information received from any source, including discovery through medical audit or follow-up on complaints, which suggests a violation of, or deviation from, State or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the California Code of Regulations, Title 22, Division 9, Chapter 6.

III. DEFINITIONS

Certificate: A valid Emergency Medical Technician (EMT) certificate issued pursuant to the California Health and Safety Code, Division 2.5.

Certifying Entity: The ICEMA Medical Director, a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT or Advanced EMT (AEMT) personnel that is approved pursuant to the standards established in the California Health and Safety Code, Section 1797.109.

Certificate Holder: For the purpose of this policy, shall mean the holder of a certificate, as that term is described above.

Discipline: Either a disciplinary plan taken by a relevant employer pursuant to the California Code of Regulations, Section 100206, or certification action taken by a medical director pursuant to the California Code of Regulations, Section 100204, or both a disciplinary plan and certification action.

Disciplinary Cause: An act that is substantially related to the qualifications, functions, and duties of an EMT or AEMT and is evidence of a threat to the public health and safety, per California Health and Safety Code, Section 1798.200.

Disciplinary Plan: A written plan of action that can be taken by a relevant employer as a consequence of any action listed in California Health and Safety Code, Section 1798.200 (c).

Functioning Outside of Medical Control: Prehospital emergency medical care which is not authorized by, or is in conflict with ICEMA policies, procedures, or

protocols, or any treatment instructions issued by the base hospital providing immediate medical direction.

Model Disciplinary Orders (MDO): The Recommended Guidelines for Disciplinary Orders and Conditions of Probation (EMSA Document #134) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

Notification of Defense: Notification sent to ICEMA by certificate holder that states certificate holder intends to defend actions through an administrative hearing process.

Prehospital Emergency Medical Personnel: People who have been certified, authorized or accredited as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.

Relevant Employer(s): Employers who provide ambulance services and/or a public safety agency where the EMT or AEMT works or was working for at the time of the incident under review, either as a paid employee or a volunteer.

IV. PROCEDURE

Responsibilities of Relevant Employer

1. Under the provisions of the California Code of Regulations and this policy, relevant employers:

    a. May conduct investigations to determine disciplinary cause.

    b. Upon determination of disciplinary cause, the relevant employer may develop and implement, a disciplinary plan, in accordance with the MDOs.

2. The relevant employer shall submit that disciplinary plan to ICEMA along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.

3. The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.

4. The relevant employer shall notify the ICEMA Medical Director within three (3) working days after an allegation has been validated as potential for disciplinary cause.

5. The relevant employer shall notify the ICEMA Medical Director within three (3) working days of the occurrence of any of following:

    a. The employee is terminated or suspended for a disciplinary cause,

    b. The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or

    c. The employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

Jurisdiction of the ICEMA Medical Director

1. The ICEMA Medical Director, or in the case where the certificate was issued by a non-local EMS agency (LEMSA) within the ICEMA region, shall conduct investigations to validate allegations for disciplinary cause when the EMT or AEMT is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the ICEMA Medical Director may take certification action as necessary against a certificate holder.

2. The ICEMA Medical Director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action against an EMT or AEMT to deny, suspend, revoke, or place a certificate holder on probation, upon the findings of any of the actions listed in the California Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:

    a. The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the ICEMA Medical Director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.

    b. The ICEMA Medical Director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.

3. The ICEMA Medical Director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:

a. The EMT or AEMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and

b. Permitting the EMT or AEMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.

4. If the ICEMA Medical Director takes any certification action, ICEMA shall notify the State EMS Authority of the findings, the certification action taken and enter the information into the State Registry.

Evaluation of Information

1. A relevant employer who receives an allegation of conduct listed in the California Health and Safety Code, Section 1798.200 (c) and the allegation is validated, shall notify the ICEMA Medical Director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).

2. When ICEMA receives a complaint against a certificate holder, ICEMA shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the ICEMA Medical Director shall perform the investigation.

3. The relevant employer or ICEMA Medical Director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

Investigations Involving Firefighters

1. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.

2. All investigations involving certificate holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

Due Process

The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

Determination of Action

1. Certification action shall be taken as a result of the findings of the investigation.

2. Upon determining the disciplinary or certification action to be taken, the relevant employer or ICEMA Medical Director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or ICEMA, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.

3. In the case of a temporary suspension order pursuant to the California Code of Regulations, Section 100209 (c), it shall take effect upon the date the notice required by the California Code of Regulations, Section 100213, is mailed to the certificate holder.

4. For all other certification actions, the effective date shall be thirty (30) days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

Temporary Suspension Order

1. The ICEMA Medical Director may temporarily suspend a certificate prior to hearing if, the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the California Code of Regulations and if in the opinion of the ICEMA Medical Director permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.

2. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the ICEMA Medical Director shall consult with the relevant employer.

3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety Within three (3) working days of the initiation of the temporary suspension by ICEMA, ICEMA and relevant employer shall jointly investigate the allegation in order for the ICEMA Medical Director to make a determination of the continuation of the temporary suspension.

a. All investigatory information, not otherwise protected by the law, held by ICEMA and the relevant employer shall be shared between ICEMA, the relevant employer and the certificate holder via facsimile transmission or overnight mail relative to the decision to temporarily suspend.

b. ICEMA shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).

c. The temporary suspension order shall be deemed vacated if ICEMA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

Final Determination of Certification Action

Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the California Code of Regulations, if the respondent chooses, the ICEMA Medical Director may take the following final actions on an EMT or AEMT certificate:

1. Place the certificate holder on probation

2. Suspension

3. Denial

4. Revocation

Placement of a Certificate Holder on Probation

The ICEMA Medical Director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. The ICEMA Medical Director may revoke the EMT or AEMT certificate if the certificate holder fails to successfully complete the terms of probation.

Suspension of a Certificate

1. The Medical Director may suspend an individual's EMT or AEMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.

2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.

3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The ICEMA Medical Director shall continue the suspension until all conditions for reinstatement have been met.

4. If the suspension period will run past the expiration date of the certificate, the EMT or AEMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

Denial or Revocation of a Certificate

1. The ICEMA Medical Director may deny or revoke any EMT or AEMT certificate for disciplinary cause that has been investigated and verified by application of this policy.

2. The ICEMA Medical Director shall deny or revoke any EMT or AEMT certificate if any of the following apply to the applicant:

    a. Has committed any sexually related offense specified under Section 290 of the Penal Code.

    b. Has been convicted of murder, attempted murder, or murder for hire.

    c. Has been convicted of two (2) or more felonies.

    d. Is on parole or probation for any felony.

    e. Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

    f. Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.

    g. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.

    h. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.

i. Has been convicted within the preceding five (5) years of any theft related misdemeanor.

NOTE: *"Felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.*

4. The ICEMA Medical Director may deny any application for certification or revoke an EMT or AEMT certificate if any of the following apply to the applicant:

   a. Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.

   b. Is required to register pursuant to the California Health and Safety Code, Section 11590.

5. Sections 1 and 2 above shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult.

6. Sections 1 and 2 shall not apply to those EMT or AEMTs who obtain their EMT or AEMT certificate prior to July 1, 2010; unless:

   a. The certificate holder is convicted of any misdemeanor or felony after July 1, 2010.

   b. The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.

   c. The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT or AEMT certification or certification renewal. Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.

7. Certification action by the ICEMA Medical Director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT or AEMT whose application was denied, or an EMT or AEMT whose certification was revoked by a medical director shall not be eligible for EMT or AEMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT or AEMTs whose certification are placed on probation must complete their probationary requirements with the LEMSA that imposed the probation.

Notification of Final Decision of Certification Action

1. For the final decision of certification action, the ICEMA Medical Director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.

2. The notification of final decision shall be served by registered mail or personal service and shall include the following information:

    a. The specific allegations or evidence which resulted in the certification action;

    b. The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);

    c. Which certificate(s) the certification action applies to in cases of holders of multiple certificates;

    d. A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.

CRIMINAL HISTORY BACKGROUND CHECKS (LIVE SCAN)

I. PURPOSE

To provide information for Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) background checks for applicants applying for certification/recertification as an Emergency Medical Technician (EMT) or Advanced Emergency Medical Technician (AEMT) recognized in California.

II. GENERAL INFORMATION

Effective July 1, 2010, all EMTs/AEMTs must have a criminal history background check (Live Scan) on file with the certifying entity.

Live Scan Forms

Live Scan forms can be printed from the ICEMA website. **It is important that the information be entered onto the form exactly as outlined in the instructions. Failure to do so will require Live Scan resubmission and additional fees.**

Forms are also available at the Live Scan agencies. If printing from the ICEMA website, applicant must print three (3) completed copies: one for the Live Scan agency, one for ICEMA, and one for the applicant.

Fees

For a list of current fees charged by the DOJ/FBI, go to http://oag.ca.gov/fingerprints/publications/contact.php. Fees related to certification are listed under "Certificates/Licenses/Permits". Additionally, each Live Scan agency charges a "rolling fee" that varies. Applicant is required to pay these fees to the Live Scan agency when submitting fingerprints.

Live Scan Agencies

A listing is available on the ICEMA and includes hours of operation, cost, whether an appointment is necessary, and acceptable methods of payment.

Conviction History

ICEMA will review all criminal convictions to determine EMT/AEMT certification eligibility. Decisions will be based on applicable State statutes and regulations and a careful review of documentation. If an applicant is denied, he/she has the right to request a hearing. In addition to certification actions, an EMT/AEMT certificate may be suspended or revoked based upon criminal history information. Applicants with a criminal conviction or who are involved in an active prosecution may

experience a delay. Applicants should submit a written explanation explaining the case and copies of court documents to facilitate the decision process. For further information, refer to ICEMA Reference #1070 - EMT/AEMT Incident Investigations, Determination of Action, Notification, and Administration Hearing Process.

What to Submit with Your Certification Application

Applicants must submit a copy of the Live Scan form with their certification paperwork. For additional certification information, refer to ICEMA Reference #1030 - EMT Certification and #1100 - AEMT Certification.

III. REFERENCES

Number	Name
1030	EMT Certification
1070	EMT/AEMT Incident Investigations, Determination of Action, Notification, and Administration Hearing Process
1100	AEMT Certification

AEMT CERTIFICATION

I. PURPOSE

To define requirements for the certification/recertification of an eligible applicant as an Advanced Emergency Medical Technician (AEMT) recognized in the State of California by the ICEMA Medical Director.

II. ELIGIBILITY

To be eligible for initial certification, an applicant shall meet the following requirements:

1. Possess a current EMT certificate in the State of California and an AEMT course completion record or other documented proof of successful completion of the topics contained in an approved AEMT training program.

2. Complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan).

3. Meet one of the following criteria:

   a. Pass the National Registry of Emergency Medical Technicians (NREMT) - AEMT written and skills examination, possess a current and valid NREMT - AEMT card and documentation of successful completion of an AEMT course.

   b. Pass the National Registry of Emergency Medical Technicians (NREMT) - AEMT written and skills examination and possess a current and valid out-of state AEMT certification card.

   c. Possess a current and valid NREMT - AEMT card.

   d. Possess a current and valid out-of-state or NREMT - AEMT certification or EMT-P license.

   e. Possess a valid California license as a Physician, Registered Nurse, or a Physician Assistant and:

      1) Documentation that applicant's training included the required course content contained in the U.S. Department of Transportation (DOT) National EMS Education Standards.

2) Documentation of five (5) ALS contacts in a prehospital field internship.

NOTE: *An applicant currently licensed in California as an EMT-P is deemed to be certified as an AEMT with no further testing required* ***EXCEPT*** *when the EMT-P license is under suspension. In the case of an EMT-P license under suspension, the EMT-P shall apply to ICEMA for AEMT initial certification.*

III. PROCEDURES

Initial Certification

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes:

   a. Copy of a valid government issued photo identification.

   b. Copy of valid EMT certification card issued in California.

   c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

   d. Copy of completed Live Scan form.

   e. Copy of valid NREMT - AEMT card.

   f. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200

   g. Disclosure of any certification or licensure action taken against any health related certification/license (EMT, AEMT, EMT-II or EMT-P). This includes any denial of certification by a local EMS agency (LEMSA), or in the case of an EMT-P, licensure denial/action by the State EMS Authority (EMSA), active investigations and actions taken in other states.

2. Submit the established ICEMA and EMSA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

NOTE: *If the applicant is not currently an ICEMA certified EMT, the State EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

3. The AEMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net.

4. The AEMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.

5. Comply with other reasonable requirements, as may be established by ICEMA.

Effective Dates

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

Recertification

To recertify as an AEMT, an applicant shall:

1. Possess a current AEMT certification issued in California.

2. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net, that includes:

    a. Copy of a valid government issued photo identification.

    b. Copy of valid AEMT certification card issued in California, unless certified by ICEMA.

    c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

    d. Copy of completed AEMT skills competency verification form, EMSA-AEMT.

    Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an applicant who is currently certified or licensed as an AEMT,

EMT-P, Registered Nurse, Physician Assistant, or Physician and who shall be designated as part of a skills competency verification process approved by ICEMA.

e. Proof of at least thirty-six (36) hours of continuing education (CE) hours from an approved CE provider.

f. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200.

g. Disclosure of any certification or licensure action taken against any health related certification/license (EMT, AEMT, EMT-II or EMT-P). This includes any denial of certification by a local EMS agency (LEMSA), or in the case of an EMT-P, licensure denial/action by the State EMS Authority (EMSA), active investigations and actions taken in other states.

3. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

NOTE: *If the applicant is not currently an ICEMA certified EMT, the EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

4. The AEMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at http://www.ICEMA.net.

5. The AEMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.

6. Comply with other requirements as may be set forth herein.

<u>Effective Dates</u>

If the AEMT recertification requirements are met within six (6) months prior to the expiration date, the effective date of certification shall be the date immediately following the expiration date of the current certificate. The certification expiration date will be the final day of the final month of the two (2) year period.

If the AEMT recertification requirements are met greater than six (6) months prior to the expiration date, the effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the

effective date.

Expiration While Deployed for Active Duty

An applicant who is deployed for active duty with a branch of the Armed Forces of the United States, whose AEMT certificate expires during the time the applicant is on active duty or less than six (6) months from the date the applicant is deactivated/released from active duty, may be given an extension of the expiration date of his/her AEMT certificate for up to six (6) months from the date of the applicant's deactivation/release from active duty in order to meet the renewal requirements for his/her AEMT certificate upon compliance with the following provisions:

1. Provide documentation from the respective branch of the Armed Forces of the United States verifying the applicant's dates of activation and deactivation/release from active duty.

2. If there is no lapse in certification, meet the requirements of "Recertification" section of this policy. If there is a lapse in certification, meet the requirements listed in the "Recertification After Lapse in Certification" section of this policy.

3. Provide documentation showing that the CE activities submitted for the certification renewal period were taken not earlier than thirty (30) days prior to the effective date of the applicant's AEMT certificate that was valid when he/she was activated for duty and not later than six (6) months from the date of deactivation/release from active duty.

   For an applicant whose active duty required him/her to use his/her AEMT skills, credit may be given for documented training that meets the requirements contained in ICEMA Reference #3030 - EMT Continuing Education Requirements while the applicant was on active duty. The documentation shall include verification from the applicant's Commanding Officer attesting to the classes attended.

Recertification After Lapse in Certification

The following requirements shall apply to an applicant whose AEMT certification has lapsed to be eligible for recertification:

1. Lapse of less than six (6) months:

   Complete all requirements in Items 2 - 6 under AEMT Recertification above.

2. Lapse of six (6) months or more, but less than twelve (12) months:

a. Complete all requirements in Items 2 - 6 under AEMT Recertification above.

b. Complete an additional twelve (12) hours of continuing education for a total of forty-eight (48) hours of training.

3. Lapse of twelve (12) months or more, but less than twenty-four (24) months:

a. Complete all requirements in Items 2 - 6 under AEMT Recertification above.

b. Complete an additional twenty-four (24) hours of continuing education for a total of sixty (60) hours of training.

c. Pass the NREMT - AEMT certifying exam.

4. Lapse of twenty-four (24) months or more:

a. Complete an entire AEMT course, ***and***

b. Comply with all requirements of Initial Certification as set forth in this policy.

Effective Dates

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

IV. REFERENCES

Number	**Name**
1090	Criminal History Background Checks (Live Scan)
3030	EMT Continuing Education Requirements

RCP AUTHORIZATION

I. PURPOSE

To define requirements for authorization/reauthorization of an eligible applicant as a Respiratory Care Practitioner (RCP) while working for an approved specialty care transport provider in San Bernardino, Inyo or Mono Counties.

II. EGILIBILITY

1. Possess a current California RCP license.

2. Current employment as an RCP by an ICEMA approved Advanced Life Support (ALS) or Basic Life Support (BLS) service provider.

3. RCPs shall have a minimum of two (2) years critical care respiratory care experience in an acute care hospital within 18 months prior to initial application.

III. PROCEDURE

Authorization/Reauthorization

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net that includes:

   a. Copy of a valid government issued photo identification.

   b. Copy of a valid California RCP license.

   c. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent.

   d. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

2. Submit any established ICEMA fees. Fees paid for authorization are not refundable or transferable. ICEMA fees are published on the ICEMA website at ICEMA.net.

3. The RCP shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at ICEMA.net.

4. ICEMA authorization will be effective from the date all requirements are verified and expire on the same date as the California RCP license, provided all requirements continue to be met.

EMT-P STUDENT FIELD INTERNSHIP REQUIREMENTS

I. PURPOSE

To define the requirements for an Emergency Medical Technician - Paramedic (EMT-P) student intern to obtain a field internship in the ICEMA region.

II. DEFINITIONS

EMT-P Student Intern: An individual who is enrolled in an approved California EMT-P training program and is required to complete a field internship in order to become eligible for a California EMT-P license.

EMT-P Preceptor: An individual licensed as an EMT-P, who has been working for an ICEMA authorized Advanced Life Support (ALS) service provider as a licensed EMT-P in the field for at least two (2) years, or an individual licensed as an EMT-P who has worked a minimum of five (5) years with one year for an ICEMA authorized Advanced Life Support (ALS) service provider, and completed an ICEMA approved preceptor training workshop. EMT-P preceptors must be in good standing with their employer and not subject to any disciplinary action against their license. Each training program is responsible for ensuring that the field preceptor has the required experience and training.

NOTE: *ICEMA approved preceptors are available to all training programs. ALS service providers may not reserve preceptors for specific training programs.*

III. ELIGIBILITY

1. To be eligible for an EMT-P student field internship within the ICEMA region, an EMT-P student intern must:

    a. Be currently enrolled in and have successfully completed the didactic and clinical rotations of an approved EMT-P training program.

    b. Possess a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent.

    c. Possess a valid American Heart Association Advanced Cardiac Life Support (ACLS) card.

    d. Currently certified as an EMT, a California AEMT, or registered as an EMT-Intermediate with the NREMT.

e. Have completed their hospital clinical shifts within the previous 90 days.

NOTE: *CPR, ACLS, and EMT certification must be maintained throughout all phases of training.*

IV. PROCEDURE

ICEMA Approved EMT-P Training Program Student Intern

1. Program director or clinical coordinator must submit the following documentation for each student interning in the ICEMA region:

   a. The name of the qualified preceptor and the name of the student they are assigned to.

   b. A letter verifying the training program administered an exam on ICEMA's policies and protocols and that the student successfully passed the exam.

   c. The date the student completed the clinical shifts (field internship must begin within 90 days from the end of the clinical rotation).

   d. Copy of a current EMT, California AEMT certification or NREMT EMT-Intermediate.

   e. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

   f. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

Out-of-Region EMT-P Training Program Student Intern

1. Program director or clinical coordinator must submit the following documentation for each student interning in the ICEMA region:

   a. A copy of the signed agreement between the training program and the approved ALS provider hosting the internship.

   b. The name of the qualified preceptor and the name of the student they are assigned to. The program director or clinical coordinator must inform ICEMA of any changes in the assigned preceptor and/or ALS provider hosting the internship.

c. The date the student completed the clinical shifts (field internship must begin within 90 days from the end of the clinical rotation).

d. Copy of a current EMT, California AEMT certification or NREMT EMT-Intermediate.

e. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.

f. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

g. Evidence of an orientation to the ICEMA region, including policies and procedures.

2. After ICEMA has approved all documents, the EMT-P student intern must schedule and pass the ICEMA EMT-P accreditation written examination with a minimum score of eighty (80%).

   a. A candidate who fails to pass the ICEMA EMT-P accreditation written examination on the first attempt will be required to re-take the exam with a minimum passing score of eighty-five (85%).

   b. Notification of the examination results shall be provided to the program director of the EMT-P training program.

   c. An out-of-region EMT-P student intern may not begin internship prior to successfully passing the ICEMA written examination.

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.

DEFINITION	ABBREVIATION
Abdomen, abdominal	Abd
Abdominal aortic aneurysm	AAA
Abduction	Abd; abd
Above knee	AK
Above knee amputation	AKA
Acquired immune deficiency syndrome	AIDS
Active range of motion	AROM
Activities of daily living	ADL
Acute myocardial infarction	AMI
Acute renal failure	ARF
Admission, admitted	Adm
Adult respiratory distress syndrome	ARDS
Advanced Cardiac Life Support	ACLS
Advanced life support	ALS
After surgery	Post op
Against medical advice	AMA
Airway, breathing, circulation	ABC
Alcohol Intoxication	ETOH
Alert & oriented to (person, place, time & event)	A & O x 4
Alert, verbal, pain, unresponsive	AVPU
Altered level of consciousness	ALOC
Ambulate, ambulating, ambulated, etc.	Amb
Amount	Amt
Ampule	Amp

DEFINITION	ABBREVIATION
And	&
Antecubital	AC
Anterior	Ant
Apparent Life Threatening Event	ALTE
Appearance, pulse, grimace, activity, respiration	APGAR
Appointment	Appt
Approximate	approx
Arterial blood gas	ABG
As soon as possible	ASAP; asap
Aspirin	ASA
At	@
Atherosclerotic heart disease	ASHD
Atrial fibrillation	A-fib; afib
Atrial flutter	A-flutter
Atrial tachycardia	A-Tach
Attention Deficit Hyperactivity Disorder	ADHD
Auscultation	Ausc
Automated External Defibrillator	AED
Automatic Implanted Cardiac Defibrillator	AICD
Bag of waters	BOW
Bag valve mask	BVM
Base Station Order	BSO
Base Station	Base
Basic Life Support	BLS
Beats per minute	Bpm
Below knee amputation	BKA
Bicarbonate, NaCO3	bicarb
Bilateral	Bilat
Blood alcohol content	BAC
Blood pressure	BP
Body Surface Area	BSA
Bowel movement	BM
Breath/bowel sounds	BS; b.s.
Bundle branch block	BBB
By mouth	PO; p.o.
Calcium	Ca
Calcium Chloride	CACL
Cancer, carcinoma	CA
Carbon dioxide	CO2
Cardiopulmonary resuscitation	CPR
Centimeter	Cm
Central Nervous System	CNS

DEFINITION	ABBREVIATION
Cerebral spinal fluid	CSF
Cerebrovascular accident	CVA
Cervical collar	C-collar
Cervical immobilization device	CID
Cervical spine	C-spine
Chest pain	CP
Chief complaint	CC; C/C
Chronic obstructive pulmonary disease	COPD
Circulation, motor and sensation	CMS
Clear bi-lateral	CBL
Complains of	C/O; c/o
Complete blood count	CBC
Computerized axial tomography	CAT
Congestive heart failure	CHF
Conscious, alert & oriented to person, place, time & event	CAOx4
Continue, continuous	cont.
Continuous positive airway pressure	CPAP
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Date of birth	DOB
Days old	d/o
Dead on arrival	DOA
Deep vein thrombosis	DVT
Defibrillation	Defib
Delirium tremor	DT
Department	dept.
Dextrose 25% (diluted D50)	D25
Dextrose in water	D5W 5%
Dextrose solution	D50 50%
Diabetes mellitus	DM
Diagnosis	Dx
Did not obtain/Did not order	DNO
Difficulty breathing	Diff Breath
Dilation and curettage	D&C
Discontinue or discharged	DC; D/C; dc
Do not resuscitate	DNR
Drops	gtts
Dyspnea on exertion	DOE
Electrocardiogram	ECG; EKG
Electroencephalogram	EEG
Emergency department	ED; E.D.
Emergency Medical Services	EMS

DEFINITION	ABBREVIATION
Emergency medical technician	EMT
Emergency medical technician-paramedic	EMT-P
Emergency room	E.R.
Endotracheal tube	ET
Epinephrine	EPI
Equal	=
Esphageal Tracheal Airway Device	ETAD
Estimated blood loss	EBL
Estimated Time of Arrival	ETA; eta
Et cetra	Etc
Ethanol (alcohol)	ETOH
Evaluation	eval.
Evening	Pm
Every	Q
Extension	ext.
Eyes, ears, nose, throat	EENT
Female	F
Fire department	FD
Flexion	Flex
Foot, feet (not anatomy)	ft.
Foreign body	Fb
Fracture	Fx; fx
Full range of motion	From
Gallbladder	GB
Gastrointestinal	GI
Gavida 1, 2, 3 etc.	G
Glasgow Coma Scale	GCS
Grain	Gr
Gram	Gm
Gunshot wound	GSW
Gynecology	GYN
Head, eyes, ears, nose, throat	HEENT
Headache	HA; H/A
Heart rate	HR
Height	ht.
Hematocrit	Hct
Hemoglobin	Hb; hgb
History	Hx
History & physical	H&P
History of	h/o
Hour	h; hr
Human immunodeficiency virus	HIV

DEFINITION	ABBREVIATION
Hydrochlorothiazide	HCTZ
Hypertension	Htn; HTN
Immediately	Stat
Inch	in.
Incident Commander	IC
Infant respiratory distress syndrome	IRDS
Inferior	Inf
Intake (input) & output	I&O
Intensive care unit	ICU
Intracranial pressure	ICP
Intramuscular	IM
Intraosseous	IO
Intrauterine Device	IUD
Intravenous	IV
Intravenous piggy back	IVPB
Intravenous push	IVP
Intravenously	IV
Irregular	irreg
Joules	J
Jugular venous distension	JVD
Kilograms	Kg
Kilometer	Km
Labor and delivery	L&D
Laboratory	Lab
Laceration	LAC
Landing Zone	LZ
Last menstrual period	LMP
Lateral	Lat
Left	L; Lt
Left bundle branch block	LBBB
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left lower quadrant of abd	LLQ
Left upper extremity	LUE
Left upper lobe of lung	LUL
Left upper quadrant of abd	LUQ
Level or loss of consciousness	LOC; loc; KO
Licensed practical nurse	LPN
Lidocaine	Lido
Liter	L
Liter per minute	Lpm; l/m

DEFINITION	ABBREVIATION
Long back board	LBB
Loss/level of consciousness (as noted by context)	LOC
Lumbar puncture	LP
Lung sounds	L/S
Magnesium Sulfate	Mag
Maximum	Max
Mechanism of injury	MOI
Medical Doctor	MD; M.D.
Medications	Meds
Mercury	Hg
Microgram(s)	Mcg
Miles per hour	Mph
Military anti-shock trousers	MAST
Millidrops, microdrops	Mgtt
Milliequivalents	MEq
Milligram(s)	Mg
Milliliter	Ml
Millimeter	Mm
Millivolt	Mv
Minimal	Min
Minute(s)	min.
Mobile intensive care nurse	MICN
Mobile intensive care unit	MICU
Moderate	Mod
Month, months old	mo; m/o
Morning	a.m.
Motor Vehicle Accident (Multi-Victim Accident)	MVA
Multiple Casualty Incident	MCI
Multiple sclerosis, morphine sulfate	MS
Myocardial infarction	MI
Narcotic	NARC
Nasal cannula	Nc
Nasogastric	NG; ng
Nasogastric (tube)	NG
Nausea/vomiting	n/v
Nausea/vomiting/diarrhea	n/v/d
Negative	neg.
Nitroglycerin	Nitro; NTG
No Acute Distress	NAD
No known allergies	NKA
No known drug allergies	NKDA
Non rebreather mask	NRB

DEFINITION	ABBREVIATION
Non Steroidal Anti-inflammatory Drugs	NSAIDS
Normal saline	NS
Normal sinus rhythm	NSR
Not applicable	N/A
Nothing by mouth	NPO
Obstetrics	OB
Occupational therapist/therapy	OT
Onset, provocation, quality, radiation, severity, time	OPQRST
Operating room	OR
Orogastric (tube)	OG
Ounce	oz.
Overdose	OD
Oxygen	O2
Oxygen Saturation	O2 sat
Palpable	Palp
Para, number of pregnancies	P
Paramedic	Medic
Paroxysmal Nocturnal Dyspnea	PAT
Paroxysmal supraventricular tachycardia	PSVT
Passenger space intrusion	PSI
Past history	P.H.; PHx
Past medical history	PMH
Patient	Pt; pt
Pediatric	Ped
Pediatric Advanced Life Support	PALS
Pelvic inflammatory disease	PID
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
Physical exam, pulmonary embolism, pedal Edema (as noted by context)	PE
Physician’s Assistant	P.A.; PA
Police department	PD
Positive	pos.
Possible	Poss
Post, after	P
Posterior	Post
Potassium	K
Potassium Chloride	KCL
Pound	lb; #
Pregnancy Induced Hypertension	PIH
Premature atrial contraction	PAC
Premature junctional contraction	PJC

DEFINITION	ABBREVIATION
Premature ventricular contraction	PVC
Prescription; intervention plan; therapy	Rx
Prior to (our) arrival	PTOA; PTA
Privately owned vehicle	POV
Psychiatric	Psych
Pulse, motor, sensation	PMS
Pulse, motor, sensory, cap refill	PMSC
Pulseless electrical activity	PEA
Pupils equal reactive to light	PERL; PEARL; PERRLA
Quart	qt.
Range of motion	ROM
Red blood cell (count)	RBC
Regarding	re:
Registered nurse	RN
Rehabilitation	Rehab
Respiration, respiratory	Resp
Respiratory rate	RR
Respiratory Therapist	RT
Response	RESPS
Rheumatoid arthritis	RA
Right	R
Right bundle branch block	RBBB
Right lower extremity	RLE
Right lower quadrant of abd	RLQ
Right upper lobe of lung	RUL
Right upper quadrant of abd	RUQ
Ringer's Lactate	RL
Rule out	R/O; r/o
Saline Lock	SL
Second(s)	sec.
Sexually transmitted disease	STD
Short(ness) of breath	SOB
Signs and symptoms	S/S; s/s
Signs, symptoms, allergies medications, past history, last intake, events	SAMPLE
Sinus Bradycardia	SB; S-Brady
Sinus Tachycardia	ST; S-Tach
Sodium	Na
Sodium bicarbonate	NaCO3
Sodium chloride	NaCl
Streptococcus	Strep
Strong and regular	S&R

DEFINITION	ABBREVIATION
Subcutaneous	sc; subQ
Sublingual	SL
Sudden Acute Respiratory Syndrome	SARS
Sudden infant death syndrome	SIDS
Supraventricular tachycardia	SVT
Tablespoon	Tbsp
Tablet	Tab
Teaspoon	Tsp
Temperature	Temp
Temperature, pulse, respirations	TPR
Three times a day	Tid
Tidal Volume	TV
Times	X
To keep open	TKO
Tracheostomy	Trach
Traffic collision	TC
Transient ischemic attack	TIA
Transport	Trans
Traumatic brain injury	TBI
Treatment	Tx
Tuberculosis	TB
Twice a day	BID; b.i.d.
Tylenol	APAP
Ultraviolet	UV
Unable to locate	UTL
Unknown	Unk
Upper respiratory infection	URI
Urinary tract infection	UTI
Venereal disease	VD
Ventricular fibrillation	V-Fib; VF
Ventricular tachycardia	V-Tach; VT
Versus	Vs
Vital signs	v.s.
Volume	Vol
Warm, dry and pink	w/d/p
Water	H2O
Watts per second	W/S
Weight	Wt
Wheelchair	w/c
Whenever necessary, as needed	Prn
White (Caucasian)	Wht
White blood cell (count)	WBC

DEFINITION	ABBREVIATION
With	$\bar{c}$
Within normal limits	WNL; wnl
Without	$\bar{s}$
Wolf-Parkinson-White	WPW
Year	Yr
Years old	Y/O; y.o.

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 is the triage tags. All patients in a MCI, regardless of the degree of injury or lack of injury, must have a triage tag.

REQUIREMENTS FOR PATIENT CARE REPORTS

I. PURPOSE

To establish requirements for the initiation, transfer, completion, review and retention of patient care reports by BLS and ALS EMS providers that is necessary to maintain medical control and continuity of patient care.

II. RESPONSIBILITIES FOR INITIATION, TRANSFER, COMPLETION AND REVIEW OF PATIENT CARE REPORTS

Initiation of Patient Care Report

- An electronic patient care report (ePCR) shall be a complete and thorough representation of all patient care provided. The report shall contain all information accumulated as a result of the patient contact that is necessary to document patient assessment and care.

- The ICEMA ePCR is the only approved report for documenting an EMS response and/or patient care by EMS field personnel (EMTs, AEMTs, EMT-Ps, MICNs, Physicians and RCPs) working in the ICEMA region.

  - EMS providers using their own electronic health record (EHR) system must comply with ICEMA Reference #2050 - Requirements for Submission of EMS Data.
  - The initiation and completion of the ePCR is the responsibility of the EMS field personnel who participate in the EMS response and/or patient care.

- An ePCR must be initiated by each EMS provider for every EMS response regardless of patient disposition.

  - If two (2) or more units from the same EMS provider are dispatched, at least one (1) EMS field personnel is required to initiate and complete an ePCR.
  - When two (2) or more units from different EMS providers are dispatched, at least one (1) EMS field personnel from each EMS provider is required to initiate and complete an ePCR.

- The EMS field personnel with the highest level of certification (EMT, AEMT, EMT-P, MICN, Physician and RCP's) from each EMS provider must initiate an ePCR whenever:

  - Contact is made with a patient.
  - The outcome of the response results in a medical assessment.

- Medical services and/or treatment are rendered.
- The patient refuses assessment and/or care.
- The patient is deceased on scene.

- EMS field personnel shall obtain and document all required ICEMA data elements, including all assessments, procedures and medications administered and provided by the EMS field personnel and members of their crews participating in the patient care.

- EMS field personnel shall only document assessment, procedures and medications administered and provided by EMS field personnel within their own organization. EMS field personnel shall not document assessment, procedures, and medications administered and provided by EMS field personnel from another EMS provider.

  - EMS providers must add student and/or intern names and certifications to their user lists so all EMS field personnel rendering care are appropriately identified on the ePCR.
  - Students must not participate in completing the ePCR.

- The use of an approved paper patient care report is only permitted as a "downtime" form when the ePCR input form or hardware is not functioning or in connection with an approved specialty or fireline paramedic program.

  - All data collected on a paper patient care report must be transferred to the approved ePCR; and
    - Must be completed and posted after the system is restored; or
    - As required by ICEMA policy for specialty or fireline paramedic programs.
  - A scanned copy of the paper patient care report must be included as an attachment to the ePCR.

Transfer of Patient Care Information and Distribution of Patient Care Reports

The ICEMA Data System is the preferred method of transfer of all patient care information between EMS field personnel, EMS providers, hospitals and ICEMA. This system ensures the transition of patient care by maintaining medical control, establishing specialty center inclusion criteria, directing treatment by subsequent healthcare providers and facilitating continuous quality improvement.

- First responders must complete the minimum documentation as described in ICEMA Reference #2030 - Minimum Documentation Requirements for Transfer of Care prior to the transfer of patient care to the transport provider.

- If the EMS transport provider is the first provider on scene, they must make all required information described in ICEMA Reference #2030 - Minimum Documentation Requirements for Transfer of Care available to EMS field

personnel participating in care at the time of transfer of patient care at the hospital or subsequent EMS transport provider using the option for "transfers" described below.

- EMS field personnel transferring patient care must initiate an electronic transfer of all required information to the accepting EMS field personnel concurrently with the verbal transfer of care.

  - For EMS field personnel using the ICEMA Data System, this may be accomplished by using the ImageTrend option of "transfers", selecting Upload and selecting the appropriate "Transfer to Agency".
  - EMS providers using their own EHR system must comply with ICEMA Reference #2050 - Requirements for Submission of EMS Data for the transfer of care between EMS providers.
  - In situations where the transfer of information is not possible due to connectivity issues, the transfer must be made at the earliest opportunity when connectivity is restored.
  - In situations where the required electronic transfer of information is not completed within 30 minutes of transfer of care, an incident report indicating the reason for the delay must be initiated and forwarded to ICEMA.

- EMS field personnel accepting the patient transfer, must accept the transfer from the transferring EMS provider concurrently with the verbal transfer of care.

  - For EMS field personnel using the ICEMA Data System, this may be accomplished by using the ImageTrend option of "transfers", and downloading by selecting the appropriate "Transfer from Agency".
  - EMS providers using their own EHR system must comply with ICEMA Reference #2050 - Requirements for Submission of EMS Data for the transfer of care between EMS providers.
  - In situations where the transfer of information is not possible due to connectivity issues, the transfer must be made at the earliest opportunity when connectivity is restored.
  - In situations where the required electronic transfer of information is not completed within 30 minutes of transfer of care, an incident report indicating the reason for the delay must be initiated and forwarded to ICEMA.

- EMS field personnel must provide the most current copy of the patient care report and all attachments to the base and receiving hospitals, at the time of transfer of care.

  - For EMS providers on the ICEMA Data System, this may be accomplished by posting to the ICEMA Data System.

- For EMS providers using their own EHR system, this may be accomplished by direct access to their data by the California Hospital Hub.

- EMS field personnel must make a copy of the patient care report available to the County Coroner if the patient is deceased and left on scene.

  - For EMS providers on the ICEMA Data System, this may be accomplished by posting to the ICEMA Data System.
  - For EMS providers using their own EHR system, this may be accomplished by direct access to their data by the California Hospital Hub.

- EMS field personnel must make a printed copy of the ePCR (PDF) and all attachments available to the accepting EMS field personnel, hospital, and/or coroner at time of transfer of care when "transfers" or posting (noted above) is unavailable.

Completion of Patient Care Reports

- The ePCR is considered completed when:

  - The report thoroughly and accurately reflects all patient care provided; and
  - All required data elements documenting patient care have been entered into the ePCR; and
  - The report is signed by the EMS field personnel (EMS primary care provider/EMS crew member) responsible to complete it.

- The ePCR must be completed, the status marked as completed and the ePCR posted concurrently with the transfer of patient care between EMS field personnel or between EMS field personnel and the hospital ED medical personnel.

- ePCRs must be locked within four (4) hours of the transfer of care.

  - The ePCR may not be unlocked to make changes unless authorized by ICEMA.
  - ICEMA may authorize unlocking a locked ePCR for changes or additions not related to patient care, such as patient demographics, destination, insurance or response times updated from CAD.
  - EMS field personnel who fail to thoroughly complete assessments, procedures, medications or other patient care details must correct errors and/or omissions on the ePCR as an addendum to the ePCR initially submitted.
  - ICEMA requested changes or addendums to ePCRs must be made within 24 hours of notification and resubmitted to ICEMA. ICEMA

may approve an extension to accommodate daily operations of EMS field personnel.
- In situations where it is not possible to lock the ePCR within four (4) hours, the EMS field personnel must send an incident report or other approved notification indicating the reason to ICEMA.

- EMS providers using their own EHR system must provide a copy of all documents generated, including the transaction history listing all changes made to the record and showing prior and current values, upon request by ICEMA.

- The EMS field personnel responsible for patient care shall accurately complete the patient care report and ensure that the ePCR:

  - Contains all data elements required by ICEMA including all assessments, procedures and medications administered and provided by the EMS field personnel and members of their crews participating in patient care.
  - Includes any additional information required by NEMSIS/CEMSIS.
  - Is signed by the EMS field personnel (EMS primary care provider/EMS crew member) who is responsible for patient care (EMS provider may require more than one signature).
  - Is completed, locked and posted according to this policy.

Review and Evaluation of Patient Care Reports

- The EMS provider is responsible to ensure that its EMS field personnel thoroughly and accurately document all patient care.

- ICEMA may view or request a copy of any completed ePCR for quality assurance and/or quality improvement. Responsibility for timely submission of requested information lies with the EMS provider.

- The EMS provider and/or hospital must provide all documentation including recordings and/or paper patient care reports, not previously posted to the ICEMA Data System, within 24 hours of the request unless otherwise agreed upon by ICEMA.

- The EMS provider is responsible for the monitoring, review, evaluation and improvement of patient care data per the EMS provider's Quality Improvement Plan.

- The EMS provider is responsible to include all ICEMA and State required EMS system quality indicators in its quality improvement program.

- ICEMA may produce system-wide statistical and quality improvement summary reports based on individual or aggregate data.

- The EMS provider is responsible for the evaluation of individual statistical or quality assurance summary reports.

III. RESPONSIBILITIES FOR RECORD/REPORT RETENTION

- All records pertaining to patient care shall be maintained by the EMS provider, hospital, and/or ICEMA as required by State and/or federal regulation. Types of records to be retained, include:

  - Records related to either suspected or pending litigation
  - Electronic Patient Care Reports (ePCR)
  - Electrocardiograms (EKG/ECG)
  - Capnography waveforms
  - EMS provider refusal of care documentation

- All ePCRs created on the ICEMA Data System will be retained as required by San Bernardino County policy or State and/or federal regulation.

- EMS providers who elect to utilize another EHR system must retain a copy of the ePCR created on their system and all related patient care documentations as required by State and/or federal regulation.

- The EMS provider shall be responsible for retention of all copies of downtime paper patient care reports or other records as required by State and/or federal regulation.

IV. PRIVACY

All EMS providers are responsible to enact policies which ensure patient privacy by restricting access and implementing electronic protections in compliance with State and federal statues, policies, rules and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

V. REFERENCES

Number	Name
2030	Minimum Documentation Requirements for Transfer of Care
2050	Requirements for Submission of EMS Data

REQUIREMENTS FOR COLLECTION AND SUBMISSION OF EMS DATA

I. PURPOSE

To establish requirements for the collection and submission of data to the ICEMA Data System by EMS providers using their own electronic health record (EHR) system as required by State regulations and ICEMA policy.

II. POLICY

All EMS providers shall utilize an EHR system that is compliant with CEMSIS and NEMSIS and contain any additional data elements required by ICEMA. EMS providers must submit data to the ICEMA Data System in real-time in order to maintain compliance with medical control to ensure the continuity of patient care within the ICEMA region.

The ICEMA Data System is the primary system for the collection and submission of EMS data in the ICEMA region and is the only authorized data system for the submission of data for reporting to the California Emergency Medical System (CEMSIS) and National Emergency Medical Information System (NEMSIS).

III. RESPONSIBILITIES OF EMS PROVIDERS

- EMS providers shall utilize an EHR system that:
  - Exports data to the ICEMA Data System in a format that is compliant with the current version of CEMSIS/NEMSIS standards.
  - Includes all additional data elements required by ICEMA, including field values and information required to identify EMS field personnel (name, identification number, etc.).
  - Includes all attachments that documents patient care, such as echocardiograms (ECGs), capnography waveforms and PDF copies of the electronic patient care report (ePCR).

- EMS providers using their own EHR system and their vendor(s) must maintain a system that:
  - Contain provisions for the electronic transfer of the patient care between EMS providers and hospitals at the time of transfer of care that:
    - Ensures that the process that is created for the transfer of patient care between EMS providers can be used by the ICEMA Data System, and

    - Ensures that the process that is created for the transfer of patient care is functionally and operationally consistent with the transfer of care procedures in the ICEMA Data System.
  - Ensures all required data is submitted to the ICEMA Data System concurrently with transfer of patient care to a subsequent EMS provider or hospital.
  - Ensures all required data is submitted to the ICEMA Data System when the record is completed and/or locked.
  - Resubmits all records, if opened and changed for any reason, at the time of the next scheduled submission of data.

- EMS providers using their own EHR system must:

  - Transmit all data elements in the Demographic Dataset as required in the NEMSIS V3 Requisite National Elements and ensure that the Demographic Dataset is updated on the ICEMA Data System with changes in the EMS provider's submitted data.
  - Notify ICEMA of any system outages in excess of 60 minutes by e-mailing the ICEMA Duty Officer.
  - Use an EHR system that exports data to the ICEMA Data System in real-time and in a format that is compliant with the current versions of the CEMSIS and NEMSIS standards that:
    - Includes all supplementary documentation and field assessment detail, such as capnography waveforms and ECGs, in a format approved by ICEMA.
    - Include EMS provider refusal of care documentation.
    - Include all signatures required by ICEMA.
  - Use the same version of CEMSIS and NEMSIS used by ICEMA.
  - Coordinate any updates to the current versions of CEMSIS and NEMSIS when implemented by ICEMA to coincide with the upgrade implementation date.
  - Include validation rules that ensure that all required data elements are captured in the ePCR.
  - Ensure that their EMS field personnel only document assessments, procedures and medications performed by EMS field personnel within their own organization.
  - Ensure that their EMS field personnel do not document assessments, procedures and medications performed by EMS field personnel from another EMS provider.
  - Use an EHR system that includes all ICEMA approved data elements and field values.
  - Allow the California Hospital Hub to access their EHR system.

- EMS providers using their own EHR system must submit a screen shot of all proposed input forms to ICEMA for approval at least 90 days prior to implementation. All changes to an approved input form(s), other than those

requested by ICEMA as noted below, must be submitted at least 10 days prior to implementation for approval.

- Screen shots must include all field titles and corresponding NEMSIS data element numbers/names and field values.
- All data elements or field values with defaulted, auto-computed or auto-filled values must be described and highlighted.

- EMS providers using their own EHR system must provide ICEMA with a detailed list of all:

  - Data elements and field values currently active in the EMS provider's EHR system.
    - Documentation must show relationship between data elements and field values in the EMS provider's EHR system with those on the ICEMA Data System.
  - Validation rules implemented on the EMS provider's EHR system.

- EMS providers using their own EHR system must submit and demonstrate a process for the electronic transfer of patient care between sending and receiving EMS field personnel at the time of transfer of patient care to ICEMA for approval 90 days prior to implementation that includes:

  - A process that creates a unified record between the sending and receiving EMS providers.
  - The ability to upload an ePCR for transfer to the other responding EMS providers that:
    - Is available for use by EMS Providers using the ICEMA Data System at the time of transfer of patient care, and
    - Allows EMS field personnel utilizing the ICEMA Data System to use the standard user interface (Transfer-Upload/Download functions), and
    - Is functionally and operationally consistent with the transfer of care procedures in the ICEMA Data System.

- EMS providers using their own EHR system must submit a printed copy of the ePCR (PDF) to ICEMA for approval at least 90 days prior to implementation. This may be the same form used by ICEMA but generated from the EMS provider's EHR system. ICEMA will provide a template upon request. The printed form must include:

  - All elements included on the current ICEMA ePCR output form.
    - Indicate all fields on EMS provider's printed form that are equal to those on the ICEMA form.
  - All supplementary documentation and field assessment detail, such as capnography waveforms and ECGs.

- EMS providers using their own EHR system and their vendor(s) must demonstrate that all ICEMA required data elements and field values are included in the datasets submitted to the ICEMA Data System that:

  - Ensures that data element numbers match those in the ICEMA Data System.
  - Provides a detailed report from the EMS provider's EHR system for all data elements and values showing element descriptions/IDs, and provide a detailed document demonstrating the process used to verify values with those in the ICEMA Data System.
  - Demonstrates the accuracy and validity of all submitted data and demonstrates real-time integration with the ICEMA Data System.
  - Ensures that all ICEMA required data elements and field values are included in the EMS provider's input/output form.

- EMS providers using their own EHR system must make any ICEMA requested changes or additions to their data sets and input forms and maintain the ability to integrate real-time data with the ICEMA Data System within the time periods specified below:

  - Make any changes or additions in priority data elements and/or values within 24 hours of notification (weekdays only). Priority items are defined as those that are necessary to comply with State regulations or medical control.
  - Make any changes or additions of non-priority data elements and/or values within 5 days of notification.
  - Ensure that all changes in either priority and non-priority data sets are implemented in the EMS provider's input/output forms at the time of the change and provide a copy of the EMS provider's revised input/output forms to ICEMA.

- EMS providers using their own EHR system and their vendor(s) must ensure that the EMS provider's EHR system is compatible with the ICEMA Data System at their own cost, and:

  - Develop and implement processes that demonstrate and test compatibility between their EHR system and the ICEMA Data System.
  - Submit a document that demonstrates the mapping of all required data elements from the EMS provider's data elements to the ICEMA data elements to ICEMA for approval at least 90 days prior to implementation of the EMS provider's EHR system (mapping that is equal between systems must be noted).

- EMS providers using their own EHR system and their vendor(s) are responsible for ensuring that all data submitted to the State or national data

repositories, via the ICEMA Data System, meet minimum validation rules for inclusion.

- EMS providers whose data is not accepted by the State or national data repositories will be excluded from further data submissions until the EMS provider can demonstrate that it is compliant with CEMSIS and/or NEMSIS standards or as required by State and/or federal regulations.

- Data submitted to the ICEMA Data System by EMS providers using their own EHR system may not be used or included:
  - In ICEMA EMS Health Information Exchange or other projects designed to facilitate the exchange of health information.
  - On the California Hospital Hub unless provisions are made for direct access to the EMS provider's EHR system by the California Hospital Hub.
  - As notification to the County Coroner through the California Hospital Hub unless provisions are made for direct access to the EMS provider's EHR system by the California Hospital Hub.

- EMS providers using their own EHR system shall reimburse ICEMA or other associated San Bernardino County departments for:
  - All costs associated with the review of EMS provider's data mapping schemas necessary for integration with the ICEMA Data System.
  - All costs necessary to monitor or verify the demonstration, testing, and/or validation of the integration of data elements and field values into the ICEMA Data System.
  - All costs for processes necessary to ensure continuity of patient care, including but not limited to:
    - Transfer of care between EMS providers and hospitals in real-time.
    - Integration of documents related to the inclusion criteria for STEMI, Stroke, and/or Trauma patients.
    - Integration of patient care information in the ICEMA specialty care registries.
    - Software enhancements to the ICEMA Data System, related to the EMS provider's EHR system, that are required to maintain current functionality for users of the ICEMA Data System.
  - All costs necessary for the processing of data or the submission of data required for State or federal data reporting.
  - All costs necessary to demonstrate, test, and or ensure that the EMS Provider's EHR system, can be integrated with the ICEMA Data System.

IV. RESPONSIBILITIES OF DISPATCH CENTERS USING COMPUTER AIDED DISPATCH (CAD)

- When CAD data is used to populate the ePCR, all dispatch centers that dispatch EMS providers using their own EHR system must submit CAD data to ICEMA in an electronic format that will:

  - Include all data elements as described in the current *NEMSIS CAD Data Standard* and submitted in a format that is compatible with the ICEMA Data System.
  - Be submitted concurrently with the medical aid request or the initiation of the response.
  - Include required data for all emergency and non-emergency medical aid requests.

CONTINUING EDUCATION PROVIDER REQUIREMENTS

I. PURPOSE

To define the requirements for approval of continuing education (CE) providers within the ICEMA region.

II. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

III. DEFINITIONS

Emergency Medical Services (EMS) Continuing Education (CE) Provider: An individual or organization approved by the requirements of Title 22, Division 9, Chapter 11, to conduct continuing education courses, classes activities or experiences and to issue earned continuing education hours to EMS personnel for the purpose of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Continuing Education: A course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

Clinical Director: A person currently licensed as a physician, registered nurse, physician assistant or paramedic. The clinical director shall have had two (2) years of academic, administrative or clinical experience in Emergency Medicine or EMS care within the last five (5) years. The clinical director shall be responsible for monitoring all clinical and field activities approved for CE credit, approving instructors and monitoring the overall quality of the EMS content of the program.

Program Director: A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations and ICEMA policy.

Instructor: A person approved by the program director and clinical director as qualified to teach the topics assigned or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

IV. PROCEDURE

1. To become an approved CE provider, an organization or individual shall submit an application packet at least sixty (60) days prior to the date of the first educational activity. The application packet shall include:

    a. Name and address of the applicant;

    b. Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;

    c. Type of organization requesting approval;

    d. Program director and clinical director resumes including copies of all licenses/certifications; and,

    e. Established ICEMA fee. ICEMA fees are published on the ICEMA website at http://ICEMA.net.

2. The applicant will be notified in writing within fourteen (14) working days that their request was received and informed if any information is missing.

3. Notice of approval or disapproval of the application will be made in writing to the applicant within sixty (60) calendar days of receipt of the completed application.

4. If the application is approved, an EMS CE provider number will be issued and valid for four (4) years.

5. If an application is disapproved and the organization or individual elects to submit a new application, the application packet must include all items listed in “1” above.

V. MAINTAINING RECORDS

1. All records will be maintained by the CE provider for four (4) years, and shall include:

a. Complete outlines for each course given including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.

b. Record of time, place, date and CE hours granted for each course.

c. A resume and copies of licenses/certifications for all instructors.

2. An ICEMA approved CE roster:

a. Signed by course participants to include name and license/certification/accreditation number of each participant. Signing for another individual is strictly prohibited and subject to actions against certification or licensure.

b. A line should be drawn through any empty lines after the last attendee has signed the roster.

c. Copies of class rosters shall be sent to ICEMA within fifteen (15) days of class completion. These rosters shall be considered final and revisions will not be accepted.

d. A record of all CE certificates issued.

3. CE providers will notify ICEMA within thirty (30) calendar days of any changes in name, address, and telephone number of the program director, clinical director or contact person.

4. All records shall be made available to ICEMA upon request.

5. The Clinical Director shall submit a complete list of courses with the number of individuals attending each course on a monthly basis to ICEMA on the ICEMA approved form. The form shall be submitted to ICEMA by the 10th of every month for the previous month. If no classes were taught, submit form with “No Classes This Month”

6. It is the responsibility of the CE provider to submit an application for renewal with the established ICEMA fee at least sixty (60) calendar days prior to the expiration date in order to maintain continuous approval.

7. All CE provider requirements required by State legislation must be met and maintained.

IV. POLICY

1. When two (2) or more CE providers cosponsor a course, only one (1) approved provider number may be used for that course, class or activity. The CE provider assumes the responsibility for all applicable provisions of Chapter 11 EMS Continuing Education.

2. The State EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS) or approved by the EMS offices of other states or courses in physical, social or behavioral sciences offered by accredited colleges and universities.

3. An approved CE provider may sponsor an organization or individual located within California that wishes to provide a single activity or course. The CE provider shall be responsible for ensuring the course meets all requirements and shall serve as the CE provider of record. The CE provider shall review the request to ensure that the course/activity complies with the minimum requirements.

EMT CONTINUING EDUCATION REQUIREMENTS

PURPOSE

To define requirements for continuing education for certified Emergency Medical Technicians (EMT's) in the Counties of San Bernardino, Inyo and Mono.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

POLICY

To maintain certification, an EMT shall:

1. Obtain at least twenty-four hours (24) continuing education hours (CEH) from an approved continuing education provider ***or***

2. Complete a twenty-four (24) hour refresher course meeting National Standard Curriculum from an approved EMT training program.

3. Complete a verification of skills competency. (EMSA Form SCV)

DEFINITIONS

1. Continuing education (CE) is a course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as the knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

2. A continuing education hour (CEH) consists of a minimum of fifty (50) minutes of approved classroom or skills laboratory activity. CE courses or activities shall not be approved for less than one (1) hour of credit. For courses greater than one CEH, credit may be granted in no less than half hour increments.

CONTINUING EDUCATION

1. Continuing education hours may be earned in the following manner:

   a. Any of the topics contained in the respective National Standard Curricula for training EMS personnel.

   b. Each hour of structural clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to this division.

   c. Each hour of media based/serial production CE (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules) A maximum of twelve (12) CE hours may be obtained in a twenty-four (24) hour period.

   d. Classroom, didactic and/or skills laboratory with direct instructor interaction

   e. Organized field care audits of patient care records

   f. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care

   g. Courses offered by accredited universities and colleges, including junior and community colleges. Acceptable courses include physical, social or behavioral sciences (i.e. anatomy, physiology, sociology, psychology) Credit shall be given on the following basis:

      1) One academic quarter unit shall equal ten (10) CE hours

      2) One academic semester unit shall equal fifteen (15) CE hours

   h. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;

   i. Sixteen (16) hours of required CEHs must come from courses involving medical management of patients. Non-medical EMS system courses (e.g. ICS, HazMat FRO, Vehicle Extrication, Rope Rescue, etc) will be limited to eight (8) hours maximum per certification cycle.

   j. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base hospital. In order to receive CEHs for precepting, all the requirements

for a course including objectives and student evaluations of the preceptors. CEHs for precepting are limited to a maximum of fifty percent (50%) of required continuing education hours per licensure/certification cycle for all EMS personnel.

k. At least fifty percent (50%) of the required CE hours must be in an instructor-based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on-line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.

l. An instructor for a CE course, class or activity will earn credit equal to the same number of CEHs applied to the course, class or activity. This shall be documented on a separate roster, clearly labeled “Instructor” and include the course name. Credit will be given, one time only, for each specific course, during a certification/licensure cycle.

m. Credit may be given for taking the same CE course, class or activity no more than two (2) times during a single certification cycle.

n. At the time of the educational event, the student must sign and provide certification/licensure number on the Continuing Education Course Roster. Failure to do so will result in loss of CE credit.

o. An individual shall provide proof of approved continuing education hours obtained to ICEMA upon request and at the time of application.

p. An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within six (6) months of the date of application may be given credit for continuing education hours earned as a Paramedic or A-EMT to satisfy the continuing education requirement for EMT recertification.

q. Continuing education may be obtained at any time throughout the current certification period.

ICEMA

Quality Improvement Plan

February 2011

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INTRODUCTION

In 1991, the California Emergency Medical Services Authority (EMSA) promulgated legislation which mandated that local Emergency Medical Services (EMS) agencies establish a system-wide quality assurance program. This legislation requires Advanced Life Support (ALS) service providers and base stations to develop and implement a quality assurance program approved by Inland County Emergency Medical Agency (ICEMA).

On January 1, 2006, EMSA implemented regulations related to quality improvement for EMS throughout the State. ICEMA's Continuous Quality Improvement Program (CQIP) satisfies the requirements of Title 22, Chapter 12, Section 4 of the California Code of Regulations.

Continuous Quality Improvement (CQI) is an ongoing process in which all levels of health care are encouraged to team together, without fear of management repercussion, to develop and enhance the EMS system. Based on EMS community collaboration and a shared commitment to excellence, CQI reveals potential areas for improvement of the EMS system, training opportunities, highlights outstanding clinical performance, audits compliance of treatment protocols and allows the review of specific illnesses or injuries and their associated treatments. This program contributes to the continued success of our emergency medical services system through a systematic process of review, analysis and improvement.

CQI implements the principles of quality improvement by defining standards, monitoring the standards and evaluating their effectiveness. It places increased emphasis on the processes of care and service rather than on the performance of individuals. It also emphasizes the role of leadership in continuous quality improvement rather than only on solving identified problems and maintaining improvement over time.

The by-product of the program is the alliance of municipal agencies and private providers that offer EMS within the ICEMA region. This provides all participants the opportunity to provide optimal service and to provide input and support to an EMS system in which they have ownership.

The ICEMA CQIP has been written in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines #166 (Rev. 03/04).

PURPOSE

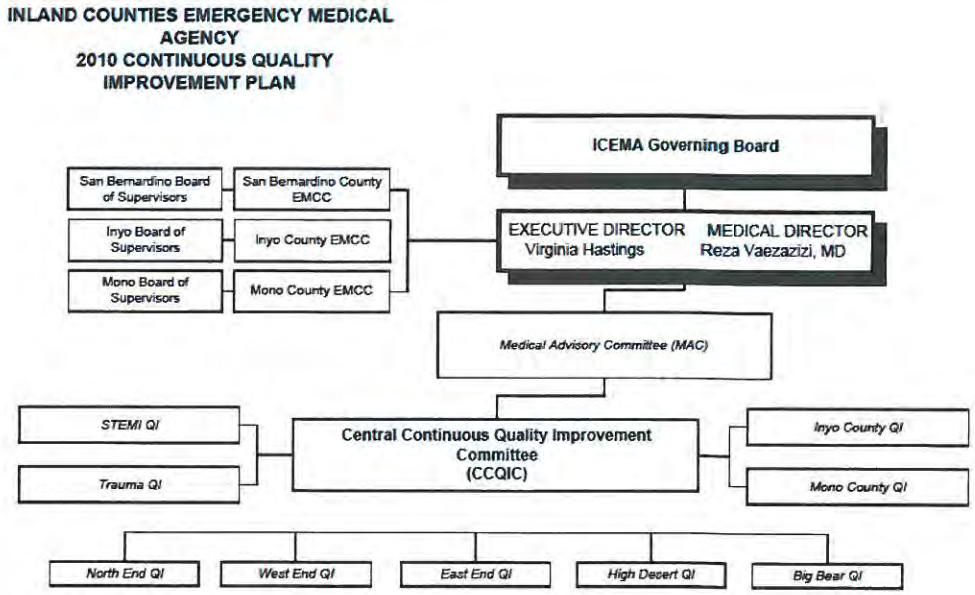
The purpose of the ICEMA CQIP is to establish a system-wide process and provide an effective tool for evaluating and improving the quality of prehospital care within the ICEMA region. This tool will focus on improvement efforts to identify root causes of problems and interventions to eliminate or reduce those problems. While striving to improve the system, the CQIP will also recognize excellence in performance and service to the stakeholders.

SECTION I - STRUCTURE & ORGANIZATIONAL DESCRIPTION

I. ORGANIZATION

ICEMA is a three county Emergency Medical Services Agency serving the counties of San Bernardino, Inyo, and Mono counties. The three counties largely provide advanced life support and basic life support services.

A. Organizational Chart



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B. Mission Statements

ICEMA

ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective EMS system including prehospital providers and specialty care hospitals.

CQI

The CQI mission is to promote the highest level of quality in prehospital care within the ICEMA region by providing CQI, education, monitoring tools and anticipatory planning.

C. Goals of the Continuous Quality Improvement Program

1. Empower EMS providers to provide consistently the highest quality of emergency medical care in the ICEMA region.

2. Provide leadership and guidance in promoting quality in the local EMS system with the cooperation of EMS providers in an educational and non-punitive environment.

3. Develop leadership to create an acceptance and belief in quality improvement and educate provider management regarding the importance of the commitment to quality improvement.

4. Provide leadership in developing programs that implement the CQI process by providing examples of high quality training and educational resources.

5. Develop and provide an atmosphere of encouragement and support that promotes excellence and personal accountability to provider personnel in all levels of management and field staff.

6. Create constancy in the CQI process to maximize efficiency and effectiveness in each EMS provider organization.

7. Promote rapid and appropriate quality treatment of all patients regardless of economic or social status in the quickest and most efficient manner possible.

8. Evaluate the benefits of new programs and procedures to provide "State of the Art" health care within the ICEMA region.

9. Provide a conduit for communication between EMS providers and other agencies to positively resolve issues in addition to providing education and encouraging growth within the EMS system.

II. STRUCTURE

A. ICEMA CQI Team

1. ICEMA is responsible for the oversight and implementation of the regional CQIP, data collection and evaluation of the EMS system in the region.

2. ICEMA CQI Team will function with direction and under the auspices of the Medical Director and Executive Director. This team shall include an educational coordinator, QI Coordinator, data analyst, ICEMA Medical Director and Executive Director.

B. ICEMA's Duties

Shall include but not be limited to:

1. Serve as the central repository of data gathered from CQI activities.

2. Provide an annual review of the CQIP for compatibility to the system and update, if needed.

3. Facilitate a performance improvement action plan with the cooperation of the appropriate EMS providers when the CQIP recognizes a need for improvement. EMS system clinical issues will require ICEMA Medical Director involvement.

4. Provide information to EMS provider advisory groups to assist in the development of performance improvement plans.

5. Work in conjunction with the EMSA to:

   - Participate in the EMSA Technical Advisory Group.
   - Assist with the responsibilities of the state-wide CQIP.
   - Assist in development, approval and implementation of State required and optional EMS system indicators.

6. Provide monitoring, data collection, reporting and evaluation of EMS system indicators from EMS providers and hospitals in the ICEMA region.

7. Identify and develop specific indicators for system evaluation based on the unique needs of the ICEMA region.

8. Annually review, expand on and improve State and local EMS system indicators as needed.

9. Provide opportunities for review of QI indicators and performance improvement plans by designated EMS providers.

10. Provide technical assistance, training and in-service education to all organizations participating in the ICEMA CQIP.

11. Provide an annual summary of activity and CQIP implementation. The summary will be provided annually to the EMSA and should include but not limited to a summary of QI indicators.

C. Description of Committees

1. Medical Advisory Committee

The Medical Advisory Committee (MAC) will function under the direction of the ICEMA Medical Director. The ICEMA Medical Director shall serve as chair and may appoint an alternate chair in his absence. The members shall have education and experience in EMS systems and regional prehospital care. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- Base Station Physician
  - Trauma Base Physicians (2 representatives)
  - Non Trauma Base Physicians (2 representatives)
- Non Base Station Physician
- Public Transport Medical Director
- Private Transport Medical Director
- Fire Department Medical Director
- Ambulance Association Representative
- EMS Nurses Representative
- EMS Officers Representative
- Inyo County Representative
- Mono County Representative

2. Central Continuous Quality Improvement Committee

The Central Continuous Quality Improvement Committee (CCQIC) will function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in evaluation of EMS data systems and EMS QI program management. The members will participate in monitoring and evaluating the CQIP. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
  - CQI Program Coordinator

- Educational Coordinator
- Data Program Coordinator

- Regional Continuous QI Committee Members (7, one from each committee)
- EMS Service Provider Medical Director (2)
  (one public and one private provider representative)
- Base Station Medical Director (2)
  (one Trauma Center and one non-Trauma Center)
- EMS Provider QI Program Coordinator (2)
  (one public and one private provider representative)
- Paramedic Training Program Representative (2)
  - Crafton Community College
  - Victor Valley Community College
- Base Station Nurse Coordinator (2)
  (one Trauma Center Paramedic Liaison Nurse (PLN) and one non-Trauma Center PLN)
- Nurse from a non-base STEMI Center
- Representatives from 9-1-1 receiving facilities emergency department representatives (2)
  (Non Base Station)
- EMT and EMT-P Representative
  Certified/licensed personnel accredited within ICEMA (2)
  (one public and one private provider representative)

3. Regional Continuous Quality Improvement Committees

Due to the size of the ICEMA region, QI Committees are regionalized under the umbrella of the CCQIC. The Regional CQI Committees (RCQIC) function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in the evaluation of EMS data system and CQIP management. The members will participate in monitoring the process as it unfolds within the system. These committees meet monthly. The members shall be multidisciplinary and include the following established committees:

- West End CQI Committee
- East End CQI Committee
- North End CQI Committee
- Big Bear CQI Committee
- Hi Desert CQI Committee (Joshua Tree/29 Palms)
- Inyo County CQI Committee
- Mono County CQI Committee

4. STEMI CQI Committee

The STEMI CQI Committee (STCQIC) functions under the direction of the ICEMA Medical Director and Executive Director. The members will have education and experience in the evaluation of Cardiovascular QI program management. The members will participate in ongoing monitoring and evaluation of the ICEMA STEMI program as it unfolds in the system. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
  - STEMI CQIP Coordinator
  - Educational Coordinator
  - Data Program Coordinator
- STEMI Center Medical Director(s)
  (One from each facility either ED Director or Cath Lab Director, or their designee)
- Base Station Medical Director (2)
  (one STEMI center and one non-STEMI center)
- EMS Provider CQI Program Coordinator (2)
  (one public and one private provider representative)
- Base Station Nurse Coordinator (2)
  (one STEMI center PLN and one non-STEMI center PLN)
- Representatives from local receiving facilities emergency department physicians (2)
  (Non STEMI center)
- Representative Advanced Life Support (ALS) Providers
  Certified/licensed personnel accredited within ICEMA (2)
  (one public and one private provider representative)
- Cath Lab Nursing Directors or designee

5. Trauma System Advisory Committee

The Trauma System Advisory Committee (TSAC) monitors trauma related care and system related issues, including air utilization. TSAC also serves as the prehospital and hospital medical care and system advisory committee. This committee meets quarterly.

TSAC functions under the direction of the ICEMA Medical Director and Executive Director. TSAC members will have education and experience in the management and evaluation of the Trauma QIP. The members will participate in ongoing monitoring and evaluation of the Trauma QIP. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director

- ICEMA Representative(s)
  - Trauma Coordinator
  - Educational Coordinator
  - Data Program Coordinator
- Trauma Center Medical Director(s)
  (one from each trauma center)
- Pediatric Trauma Attending(s)
  (one from each trauma center)
- Base Station Medical Director (2)
  (one from a trauma center and one from a non-trauma center)
- Non-Trauma Center Emergency Department Physicians
  (with an interest in trauma care)
- Trauma Center Coordinator (2)
  - ARMC
  - LLUMC (Adult)
  - LLUMC (Pediatric)
- Trauma Center PLNs
  (one from each trauma center)
- EMS CQI Program Coordinators
- Prehospital Personnel
  - Fire Chief's Association Representative
  - Ambulance Representative
  - Air Rescue Representative
  - Coroner or Representative

6. Trauma and Air Audit Committee

ICEMA participates in a joint San Bernardino County and Riverside County Quality Improvement committee called Trauma and Air Audit Committee (TAAC). TAAC is a closed, regional QI committee addressing multi-county system and medical issues. This committee meets quarterly. The TAAC committee is comprised of representatives from both San Bernardino and Riverside Counties:

- Riverside EMS Agency Representatives
- ICEMA Representatives
- Medical Directors (ED/Trauma and non-trauma hospital)
- Nurse Managers (ED/Trauma and non-trauma hospital)
- Trauma Hospital Paramedic Liaison Nurses (PLNs)

D. Term of Committee Memberships

Term of Membership shall be two (2) years expiring December 31 and subsequent new terms shall begin January 1. The terms shall be staggered so that no more than two-thirds of the membership shall expire in any one-year period. A member whose term has expired shall continue to serve until a new appointment is confirmed. Members may be reappointed.

E. Attendance

1. Members will notify ICEMA in advance of any scheduled meeting they will be unable to attend.

2. At the discretion of ICEMA, other individuals may participate in the meetings when their expertise is essential to make appropriate determinations.

3. The absence of a committee member from two (2) consecutive meetings of the committee shall be cause for the Chairman to contact the committee member to discuss participation in the meetings. Whenever a committee member fails to attend two (2) consecutive meetings or three (3) total meetings in a calendar year, without good cause, the Chairman shall discuss with the committee and recommend the members removal from the committee.

4. Resignation from the committees must be submitted, in writing, to ICEMA, and is effective upon receipt, unless otherwise specified.

F. Chairperson

The ICEMA Medical Director shall serve as chair of the CCQIC. Other committees will allow nominations and voting for a Chairperson and a Co-Chairperson. The term of elected members will be for two (2) years.

G. Voting

Due to the advisory nature of these committees, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Chairperson. When voting is required, a simple majority of the members present will constitute a quorum. The chair will break any tie vote.

H. Alternate Members

Alternate members may serve as a representative of an appointed member in the event that an appointed member is unable to attend scheduled meetings due to conflict in scheduling and/or illness. The appointed member must designate in writing the alternate member to serve in his/her absence. The written notice must be submitted to and approved by ICEMA at least five (5) working days prior to a scheduled meeting. Alternate members shall not be utilized on a regular basis.

I. Minutes

Minutes will be kept by a designee from ICEMA and distributed to the members prior to each meeting. Due to the potential need for confidentiality, certain documents may be collected by the ICEMA staff at the close of each meeting and no copies may be made or processed by members of the committee without written consent from ICEMA.

J. Responsibilities

1. If a representative is unable to attend a meeting, he or she is responsible to appoint an alternate for attendance and representation as mentioned above under "Alternate Members".

2. Disseminate non-confidential information, as appropriate, and discuss at meetings to the represented groups.

3. Determine indicators for system evaluation based on EMS QI indicators and identify and develop other indicators as deemed necessary.

4. Re-evaluate and improve locally developed EMS system indicators annually or as needed.

5. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement CQIP templates.

6. Recommend the chartering of RCIQCs and review of their reports.

7. Seek and maintain relationships with all EMS participants including, but not limited to:

   - State EMSA
   - Other Local EMS Agencies (LEMSAs)
   - EMS Service Providers
   - Local Departments of Public Health
   - Specialty Care Centers
   - Law Enforcement
   - Public Safety Answering Points (PSAPs)
   - Dispatch Centers
   - Constituent Groups

K. Confidentiality

All proceedings, documents and discussion of the committees are confidential and are covered under Sections 1040, 1157.5, and 1157.7 of the Evidence Code of the State of California. The prohibition relating to the discovery of testimony provided to the committees shall be applicable to all proceedings and records of this group, which is established by a local government agency as a professional standards review organization. This organization is designed in a manner which makes available professional competence to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to prehospital care services. Guests may be invited to discuss specific issues in order to assist in making final determinations. Guests may only be present for the portion (s) of the meeting about which they have been requested to review or testify.

All members shall sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through committee membership. Prior to the invited guests participating in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement for invited guests.

III. PARAMEDIC BASE STATION REQUIREMENTS

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The Base Station CQIP should involve all EMS system participants including, but not limited to dispatch agencies, ALS and BLS service providers, receiving hospitals and Critical Care Specialty Hospitals.

1. Structure

The Base Station CQIP shall be reviewed by ICEMA for compatibility with the State CQIP guidelines. The organizational chart should reflect the integration of the CQIP in the organization.

Listed below are minimum requirements of Base Station CQIP:

a. A CQI Team under the direction of the Base Station Medical Director. Lead staff should have expertise in management of the Base Station's CQIP. The following staffing positions are identified (note: organizations with limited resources may combine positions):

- Base Station Medical Director (or designee)
- EMS QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural facilities. It is understood that there are variances in staffing and staff responsibilities.

b. An internal CQIP Technical Advisory Group with members, which include but are not limited to:

- Base Station Medical Director
- Prehospital Liaison or Equivalent
- Base Station Mobile Intensive Care Nurse (MICN)

2. Responsibilities

The Base Station CQI Team should be a primary source of EMS activity reporting for state-wide and regional EMS system indicators. The Base Station CQIP will perform the following functions:

a. Cooperate with ICEMA in carrying out the responsibilities of the ICEMA CQIP and participate in the ICEMA CQI process.

b. Cooperate with ICEMA in the implementation of State required EMS system indicators.

c. Cooperate with ICEMA in monitoring, collecting data, and evaluating State required and ICEMA EMS system indicators.

d. Cooperate with the EMSA and ICEMA in the re-evaluation and improvement of State and local EMS system indicators.

e. Participate in meetings for internal review of Base Station indicators and development of performance improvement programs related to the findings.

f. Establish a mechanism to incorporate input from ICEMA, service providers and other hospitals for the development of performance improvement programs.

g. Assure reasonable availability of CQIP training and in-service education for Base Station personnel.

h. Prepare plans for expanding or improving the Base Station CQIP.

i. Provide technical assistance to all EMS provider's CQIPs in the Base Station's jurisdiction.

3. Annual Reports

Base Stations must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

B. REVIEW OF PATIENT CARE DATA

1. Mobile Intensive Care Nurse Report

A minimum of 30 (or the total if <30) randomly selected MICN reports , or 10%, whichever is greater, will be reviewed monthly by the PLN and/or Base Station Medical Director, or designated peer review staff, for the following:

a. Complete documentation.
b. Prehospital patient care treatment orders.
c. Compliance with ICEMA protocols.

2. Base Station Audio File Reviews

All audio files that fall into the following categories must be reviewed for determination of cause and must be logged and included in the quarterly report submitted to ICEMA:

a. A case review request is submitted.
b. Any call where a physician has ordered an EMT-P to administer a medication or perform a skill that is out of his scope of practice, or in deviation with protocol.
c. Runs involving internal disaster or trauma diversion.
d. High profile cases.

3. Concurrent/Retrospective Clinical Review Report

The CCQIC may select a clinical topic on a quarterly basis to be audited by the Base Stations and provider agencies. Examples are cardiac arrest, head trauma and respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen, utilizing data obtained from electronic patient care records (e-PCRs). Examples may include timely administration of ACLS medications, documentation of responses to the administration of medications and/or procedures. This report will be forwarded to ICEMA and may be used to determine recommendations to the ICEMA Medical Director regarding the appropriateness of certain drugs, equipment, procedures, etc., for improvement in the delivery of quality patient care in the EMS system.

4. Base Station Statistics

Base Stations are required to keep on-going statistics for periodic review by the EMS agency staff. Requirements for documentation in this log are included in the Base Station Statistics Policy and Base Station Data Collection Tool. Monthly reports shall be submitted as required by ICEMA.

5. Case Review Reports

A confidential file of case review reports will be maintained by the PLN and/or Base Station Medical Director. Documentation should include the case review report and any other pertinent data. The case review report is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors without prior written notification. See QI Form 008, 009 and 010.

The laws protecting the discoverability of information received through the quality assurance process state very clearly that information must be maintained in a confidential manner. Breaches that result in loss of the confidentiality of these records allow the information to be accessible to

discoverability and seriously jeopardize the quality assurance/quality improvement process. All case review records must be kept in a confidential file and maintained to protect all parties involved.

6. Radio Communication Failure Reports

The Base Station Medical Director or PLN will be required to report any radio equipment failures to ICEMA within 72 working hours. See QI Form 001.

7. Quarterly Reports

Quarterly reports must include all relevant information and be forwarded to ICEMA at the first of every quarter (the first of January, April, July and October). Requirements for these reports are illustrated in the Quarterly Report Form. See QI Form 007.

IV. EMERGENCY MEDICAL SERVICE PROVIDER

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The EMS Provider's CQIP should involve EMS system participants including but not limited to dispatch agencies, ICEMA, training programs, hospitals, specialty care centers and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended.

CQIP's should include indicators, covering the areas listed in the California Code of Regulations, Title 22, Chapter 12 of the Emergency Medical Services System Quality Improvement Program, which address, but are not limited to, the following:

- Personnel
- Equipment and Supplies
- Documentation and Communication
- Clinical Care and Patient Outcome
- Skills Maintenance/Competency
- Transportation/Facilities
- Public Education and Prevention
- Risk Management

Indicators should be tracked and trended to determine compliance with their established thresholds as well as reviewed for potential issues. Indicators should be reviewed for appropriateness on a quarterly basis with an annual summary of the indicators performance. Air Medical Providers may reference CAMTS to identify potential indicators they may wish to implement in their system.

ALS Provider agencies must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

1. Structure

The EMS Provider's CQIP shall be reviewed and approved by ICEMA for compatibility with the guidelines.

The organizational chart shall reflect the integration of the CQIP in the organization. The EMS Provider's CQIP should include the following:

a. An EMS CQI Team under the direction of the EMS Provider's Medical Director or EMS Administrator. Lead staff should have

expertise in management of the EMS provider's CQIP. The following staffing positions are identified:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural agencies. It is understood that there are variances in staffing and staff responsibilities (organizations with limited resources may combine positions).

b. An internal CQI Technical Advisory Group with members including, but not limited to:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- Chief/EMS Administrator or designee.
- QI Program Coordinator.
- Service Personnel (Physicians, RNs, Paramedics, EMTs).
- Other system participants.

2. Responsibilities

The EMS Provider's CQIC should be the primary source of CQIP activity reporting for state-wide and local EMS system information. The EMS Provider's CQIC will perform the following functions:

a. Cooperate with ICEMA in carrying out the responsibilities of ICEMA's CQIP and participate in ICEMA's CCQIC.

b. Cooperate with ICEMA in the implementation of State required EMS system indicators.

c. Cooperate with ICEMA in monitoring, collecting data, and evaluating the State and regional/local EMS system indicators, both required and optional.

d. Cooperate in the re-evaluation and improvement of State and local EMS system indicators.

e. Conduct meetings for internal review of EMS provider information and development of performance improvement programs related to the findings.

f. Establish a mechanism to receive input from ICEMA, other service providers and other EMS system participants for the development of performance improvement programs.

g. Assure routinely scheduled CQIP training and in-service education for EMS provider personnel.

h. Prepare plans for expanding or improving the EMS Provider's CQIP.

i. Participate in meetings and presentations of state and local EMS system information for peer review to local designated advisory groups and other authorized constituents.

3. Annual Reports

The EMS Provider's CQI Team will annually publish summary reports of CQIP activity for distribution to ICEMA and other groups as determined.

B. ALS STAFFING REQUIREMENTS AND RESPONSIBILITIES

1. ALS Provider Agency Medical Director Guidelines

Shall be a physician licensed in the State of California with experience in emergency medical care. Must be knowledgeable of the policies, protocols, and procedures set forth by ICEMA.

2. ALS Provider Agency Medical Director Responsibilities

a. Demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader for the organization, providing educational opportunities, training, support and encouraging communication of skills to facilitate the team building network.

b. Shall be responsible for coordinating and implementing an approved provider agency CQIP that focuses on the opportunity for improvement as well as identification and prevention of potential concerns within the organization, implements resolutions to these problems and evaluates the outcome, as well as provides the positive recognition when an opportunity is provided.

c. Shall provide a written operational protocol manual for approval by ICEMA (applies only to Air Transport Teams utilizing flight nurses in the EMS region).

3. ALS Provider Agency Quality Improvement Coordinator Requirements

Each ALS provider agency shall have a CQI Coordinator. This person shall be either: 1) a physician, registered nurse or physician assistant that is licensed in California and has experience in emergency medicine and emergency medical services or 2) a paramedic who is or has been licensed in California within the last two (2) years and who has at least two (2) years experience in prehospital care.

4. ALS Provider Agency Quality Improvement Coordinator Responsibilities

a. Shall act as a liaison between the prehospital personnel and the Base Station Medical Director, PLN, ED physician, other provider agencies and ICEMA.

b. Shall initiate, implement and evaluate the agency's quality improvement program.

c. Shall be responsible for monitoring documentation of program operations within the agency, as required for evaluation by ICEMA.

d. Shall monitor EMS personnel compliance to policies, procedures and protocols and ability to function within the scope of practice.

e. Shall demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader when providing training and educational opportunities, encouragement, support and communication skills to promote an EMS system that delivers the best available patient care.

f. Shall participate in their regional CQI committees and Base Station CQI process.

C. REVIEW OF PATIENT CARE DATA

1. ALS Run Report Forms

A minimum of thirty (or the total if <30) randomly selected ALS runs, or 10 %, whichever is greater, must be reviewed each month by the CQI Coordinator or by the designated peer review staff for at least the following:

a. Complete documentation.
b. Ordering of prehospital patient care treatment.
c. Compliance with protocols.

d. Response times and prolonged on-scene times
e. E.T. attempts and placement.
f. MCI as defined by Protocol Ref. #5050, Multi-Incident Operational Procedures (review with Paramedic PLM).
g. Proper documentation of Against Medical Advice (AMA) forms (review with PLN).

2. Concurrent and Retrospective Clinical Review Topics

The ICEMA Regional CQIC may select a clinical topic on a quarterly basis to be audited by the Base Station and ALS Provider agencies; examples; cardiac arrest patients, patients with head trauma, respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen (utilizing data obtained from e-PCRs). Examples of this may include: timely administration of ACLS drugs, documentation of responses to the administration of medications and/or procedures. These reports will be forwarded by the Base Station to the committee and may be used to determine recommendations to the ICEMA Medical Director.

3. ALS Provider Agency Log

ALS Provider agencies will be required to keep an on-going log for periodic review by ICEMA. Requirements for documentation in this log are spelled out in the Quality Improvement Log Form. See QI Form 005.

A confidential file of case review reports will be maintained by the Provider Agency CQI Coordinator and/or ALS Provider Agency Medical Director in accordance with specifications under CASE REVIEW FORMS, Section IV. Documentation should include the case review report and any pertinent data. This is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors.

V. CASE REVIEW FORMS/CASE REVIEW CONFERENCE

A. INITIATING A CASE REVIEW

To request that a call be reviewed, a Case Review Form must be initiated, and forwarded to the QI Coordinator, ALS Provider Agency Medical Director, PLN or Base Station Medical Director. The report should be forwarded to the person responsible for reviewing the incident within the agency or facility. For example, if an EMT-P initiates a report, EMT-P should forward it to the agency QI Coordinator for review. If an MICN initiates a report, MICN should forward the report to the PLN. See QI Form 008.

A Case Review Form may be initiated by any physician, MICN, EMT-P, or EMT, who feels that any of the following have occurred:

- Treatment/action resulting in positive patient outcome.
- Patient care related to an adverse patient outcome.
- Deviation from ICEMA treatment protocols.
- Conflicts with existing State law and/or ICEMA policy.
- Situations that pose a threat to the safety of patients or providers of prehospital care.
- Situations that serve as an educational tool for EMS providers.

When the request involves the QI Coordinator, PLN or Medical Director normally responsible for the initiation of the case review form, the request should be forwarded to ICEMA.

If there is any doubt as to who is the responsible reviewing party, ICEMA will provide direction.

B. CONDUCTING A CASE REVIEW

Upon receipt of a Case Review Form, the person responsible for the investigation shall:

- Review the EMS patient care record, MICN record, Base Station wave, and the patient outcome records (if applicable).
- Collect statements from the involved personnel if needed to determine action necessary.
- Establish the need for further action.
- Involve the appropriate agency representatives (i.e., ALS Provider Agency QI Coordinator should contact the PLN and Base Station Medical Director if determination of further action is necessary).
- Conduct a Case Review Conference, if necessary. See QI Form 010.

C. CONDUCTING A CASE REVIEW CONFERENCE

1. Responsible Reviewing Party

The responsible reviewing party shall notify the appropriate personnel and determine a time and date that the Base Station Medical Director, PLN and all involved personnel can attend the Case Review Conference (CRC). A CRC must be done within thirty (30) days of the decision to conduct a CRC unless it meets the exception criteria.

Exception Criteria:

a. Involved personnel could not be contacted (written explanation required in summary).
b. Documents needed for review could not be gathered in this time frame (explanation must be included in summary).

2. Review of Information

The Case Review Conference will require a review of all information necessitating the conference and any additional information that may be pertinent to the review. The Medical Director is responsible for determining the need for further action. The Medical Director may make the determination that the incident requires one of the following:

a. Positive Recognition:

A CRC may be held to evaluate outstanding performance to be utilized for positive education feedback. An evaluation and recommendations report shall be forwarded to the ICEMA Medical Director.

b. No Further Action Necessary:

Complete a Case Review Conference Report stating the conclusion of the review and forward a copy of the report to the ICEMA Medical Director. Maintain the original document in the Case Review Report File.

c. Need For Education:

The Base Station Medical Director or Agency Medical Director shall determine if the need for education is related to an individual or is of an educational value to the EMS system, or both.

d. EMS System Education:

The review has led to the opportunity to provide educational value to benefit the system (i.e., a piece of equipment has proven to be defective when used in certain environments). A Case Review Conference Report shall be completed and a copy forwarded to the ICEMA Medical Director. Maintain the original report in the Case Review Report File. Suggestions for system-wide improvements will be submitted to ICEMA CCQIC and the EMCC, and addressed through education.

3. Plan of Action

The determination has been made that an individual or individuals would benefit from the initiation of the education process.

a. Identify the Area of Improvement - i.e., skills deficiency, lack of working knowledge of ICEMA protocols, etc.

b. Recommend a Plan of Action - For example, the Base Station or ALS provider agency may be requested to provide skills training, further monitoring, protocol updates, etc. In this circumstance, the ICEMA Medical Director will request follow-up in writing from the ALS provider agency and will determine the period in which this is to be provided. Complete the Case Review Conference Report (QI Form 008) providing the appropriate information and forward a copy to the ICEMA Medical Director upon completion of the conference. Maintain the original Case Review Conference Report in the Case Review Report File.

c. Initiate the Plan of Action - Provide the education, monitoring, etc., as determined by ICEMA Medical Director.

d. Evaluation of the Outcome - The ICEMA Medical Director will evaluate the outcome of the process, the need to re-evaluate at a future date if necessary or to provide further education. This information should be included in follow-up form on a Case Review Conference Report and a copy submitted to the ICEMA Medical Director. Maintain the original report in the Case Review Report File.

4. Disciplinary Action Needed

The need for disciplinary action should only be initiated if ICEMA's Medical Director determines the situation reflects grounds for disciplinary action under Chapters 4 and 6 of the California Code of Regulations (CCR), Title 22. All pertinent information should then be forwarded immediately to the ICEMA Medical Director for consideration of further action.

SECTION II - DATA COLLECTION AND REPORTING

Data collection and reporting are two of the most important elements in CQI. The data collected must be valid, reliable, and standardized with all other system participants. ICEMA encourages the sharing of data through summary reports among all EMS system participants.

This chart provides suggested indicators for each Indicator category per organizational structure. Use of these indicators is not mandatory.

Assumptions: 1. California EMS Information System (CEMSIS) will provide state-wide data.

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Personnel	WELLNESS WORKLOAD POLICIES AND PROCEDURES LICENSURE ED1 Education and Training Indicator A - H	WELLNESS WORKLOAD POLICIES AND PROCEDURES CERTIFICATION /ACCREDITATION ED1 Education and Training Indicator A - D, G, H	WELLNESS WORKLOAD POLICIES AND PROCEDURES ED1 Education and Training Indicator A, B (if provider has EMT-I training school)	WELLNESS WORKLOAD POLICIES AND PROCEDURES BH1 Base Hospitals-Activity Indicator B - D
Equipment and Supplies	ePCR INVENTORY CONTROL	COMMUNICATIONS COVERAGE	PREVENTIVE MAINTENANCE PLANS PHARMACEUTICALS	INVENTORY CONTROL
Documentation		DATA VALIDATION ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	DATA VALIDATION NARCOTIC RECORDS ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	TIMELINESS ACCURACY OUTCOME REPORTING QUALITY REVIEW PROCESSES
Clinical Care and Patient Outcome	SCOPE OF PRACTICE COMMITTEE STRUCTURE RESEARCH CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - B	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach -Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J MA1 ALS Staffing Levels Indicator A - D RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B, N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B, N CA3 Chest Pain-Suspected Cardiac Origin Indicator J RE1 Shortness of Breath Bronchospasm Indicator G RE2 Shortness of Breath Fluid Overload Indicator K

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Skills Maintenance/Competency	SCOPE OF PRACTICE	SCOPE OF PRACTICE SKILLS UTILIZATION BENCHMARKING SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES (BENCHMARKING) SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES
Public Education and Prevention	COMMUNITY INVOLVEMENT PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1A Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B
Risk Management	ISSUE RESOLUTION PROCESS SYSTEM MONITORING	ISSUE RESOLUTION PROCESS SYSTEM MONITORING CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B MA1 ALS Staffing Levels Indicator A - D	ISSUE RESOLUTION PROCESS OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONNEL SAFETY SYSTEM MONITORING MA1 ALS Staffing Levels Indicator A - D RS1 Response Indicator A - C SK1 Skills – Advanced Provider Indicator A - J	OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONAL SAFETY SYSTEM MONITORING

SECTION III - EVALUATION OF INDICATORS

The ICEMA QI Coordinator will analyze the quality indicators on a monthly basis and then create relevant reports for presentation to the MAC and/or EMCC.

SECTION IV - ACTION TO IMPROVE

I. FOCUS-PDSA

Once a need for improvement in performance has been identified by ICEMA, MAC or the EMCC, ICEMA will be utilizing the FOCUS-PDSA model for performance improvement. FOCUS-PDSA involves the following steps:

Find a process to improve - the CCQIC will identify improvement needs.

Organize a team that knows the process - the CQI Team will form Task Force(s) as needed and review process documents.

Clarify current knowledge of the process - review indicator trends relevant to the process, collect other information

Understand - causes of process variation utilizing tools, such as fishbone diagrams, Pareto analyses, etc.

Select - process improvement to reduce or eliminate cause(s).

Plan - State objective of the test, make predictions, develop plan to carry out the test (who, what where, when).

Do - Carry out the test, document problems and unexpected observations, begin analysis of the data.

Study - Complete the analysis of the data, compare the test data to predictions, and summarize what was learned.

Act - What changes are to be institutionalized?
What will be the objective of the next cycle?
What, if any, re-education or training is needed to effect the changes?

Once a Performance Improvement Plan has been implemented, the results of the improvement plan will be measured. Changes to the system will be standardized and/or integrated. A plan for monitoring future activities will be established.

II. MEETINGS

During its quarterly or other meetings, ICEMA or MAC may identify indicators that signal a need for improvement and make recommendations for chartering a Quality Task Force, if needed. ICEMA or the CCQIC may select members and charter a Task Force with a specific objective for improvement. Each Task Force will use the FOCUS-PDSA model to conduct improvement planning and prepare recommendations or a report for review by ICEMA. ICEMA will prepare a report including the findings and recommendations of the Task Force and make recommendations to the Task Force and prepare the report for distribution to the MAC. ICEMA will also disband the Quality Task Force at the appropriate time.

Presentation of quality indicator analyses will most frequently be in a run chart, a Pareto chart, or a histogram format. This will enable ICEMA and/or MAC to easily identify trends and to rapidly interpret the data.

ICEMA, CCQIC and MAC will meet at least quarterly to evaluate and discuss the data provided by the ICEMA QI Coordinator according to the following agenda:

- Review of prior meeting action items.
- Presentation of indicators and results/trends.

  For each indicator that the CCQIC reviews, the following process will be followed:

  - Identify the objectives of the evaluation.
  - Present indicators and related EMS information.
  - Compare performance with goals or benchmarks.
  - Discuss performance with peers/colleague.s
  - Determine whether improvement or further evaluation is required.
  - Establish plan based upon decision.
  - Assign responsibility for post-decision action plan.
- Examine correlations between/among trends.
- Acknowledgement of positive trends; discussion of unsatisfactory trends.
- Receive reports from Quality Task Forces, if any.
- Discuss changes needed to indicators.
- Recommend the chartering of Quality Task Forces, if any.
- Provide input to ICEMA to regarding improvement priorities.
- Summarize action items identified at this meeting.

- Recommend training/educational needs.
- Evaluation of the meeting.

SECTION V - TRAINING AND EDUCATION

Once the decision to take action or to solve a problem has occurred, training and education are critical components that need to be addressed. Education needs will be identified in reports given at quarterly MAC and CCQIC meetings. The EMS Agency will make recommendations for educational offerings county-wide based on these reports and reports from CQI Task Forces.

Once a Performance Improvement Plan recommended by a Task Force, the ICEMA QI Team, or MAC has been implemented, ICEMA will standardize the changes within the appropriate policies and procedures. The EMS Specialist responsible for educational oversight maintains the Policy and Procedure Manual, which is updated twice per year. Changes recommended by a Quality Task Force or other system participants are implemented via policy changes or new policies being written as indicated. The new policy or change in policy is presented at the various EMCCs for discussion. Changes may be made based on those discussions. The policy is then posted on the ICEMA website at www.ICEMA.net for a 45-day public comment period. Final changes to the policy are made based on public comments received. The new or improved policy is then implemented. If additional training is required of system participants, time is allotted for that training prior to the implementation of the policy. Policies also may be changed to comply with State or Federal mandates. These changes are written into the policies and are discussed at various committee meetings and the EMCCs and posted on the ICEMA website, but do not go out for a public comment period.

The EMS Specialist who is responsible for educational oversight also ensures that providers submit documentation that all training requirements have been met by all EMS system participants, usually twice per year and on an as-needed basis. This is accomplished via training memos, training program development, or by train-the-trainer programs. Providers are ultimately responsible for ensuring that staff is adequately trained. The rosters and records of training are available to ICEMA upon request.

SECTION VI - ANNUAL UPDATE

The Annual Update is a written account of the progress of an organization's activities as stated in the EMS CQIP. An EMS Specialist is responsible for annually updating the EMS Plan, in alignment with current EMS strategic goals. The CQI Coordinator will do an initial review of the CQIP, identifying what did and did not work. The CQI Coordinator will work in conjunction with the EMS Specialist responsible for updating the EMS Plan to ensure that both the CQIP and the EMS Plan are focusing on the same objectives. Once both the CQIP and the EMS Plan have been reviewed in this fashion, the CQI Coordinator will present his/her findings to the CCQIC and to the CQI Team.

The following chart will be the template for the presentation of the update.

Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan/Plans for Further Action	Were Goals Met? Is Follow-up Needed?

As part of the Annual Update, the ICEMA CQI Team and the CCQIC will offer recommendations for changes needed in the CQIP for the coming year, including priority improvement goals/objectives, indicators monitored, improvement plans, how well goals/objectives were met, and whether follow-up is needed.

A current CQIP will be submitted to the State EMS Authority every five (5) years.

LICENSURE CHANGES 911 RECEIVING HOSPITALS

PURPOSE

To establish a policy and procedure for 9-1-1 receiving hospitals to down-license or close emergency departments or identified specialized services and provide a mechanism for ICEMA to evaluate and report on the potential impact on the EMS system within the region.

AUTHORITY

California Code of Regulations 70105(a), 70107(a), 70107(a)(12), 70351(a), 70351(b)(1), 70701(a)(4), Health & Safety Code Section 10017(d), Section 1300.

PRINCIPLES

1. Hospitals with a basic or comprehensive emergency department permit provide a unique service and an important link to the community in which they are located. In certain instances, the withdrawal or reduction of these services may have a profound impact on the emergency medical services available to the community at large and to the EMS system.

2. Every effort should be made to ensure that emergency medical services considered essential be continued until emergency care can be provided by other facilities or until prehospital care providers can adjust deployment of resources to accommodate anticipated needs.

3. ICEMA should have sufficient time and opportunity to examine the impact that down-licensing or closure of an emergency department will have on a community before any changes are finalized. Such an examination shall be referred to as an EMS Impact Evaluation.

4. Hospitals can be prioritized utilizing objective criteria, referred to as the EMS Impact Evaluation Rating Instrument, to determine the relative level of essential value a hospital has within the system. This rating can be used to ascertain whether ICEMA will request the Licensing and certification Division, operating as agents of the California Department of Health Services, to delay approval of a request to down license or to close an emergency department or the specialized services outlined in Principle No. 3.

PROCEDURE

1. Any hospital proposing to downgrade or eliminate emergency services in its facility shall provide a ninety (90) day written notice to the California Department of Health Services, ICEMA and all health service plans under contract with the hospital.

2. The hospital shall provide public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

3. ICEMA, in consultation with appropriate health care providers, shall complete an EMS Impact Evaluation. The report shall include, but not be limited to, the following areas:

   - **Geography:** Service area population density, travel time and distance to the next nearest facility, number and type of other available emergency services, availability of prehospital resources

   - **Base Hospital Designation:** Number of calls; impact on patients, prehospital personnel, and other base hospitals

   - **Level of Care:** Assessment of level of emergency services provided, (i.e. basic, standby) and next nearest availability

   - **Trauma Care:** Number of trauma patients; impact on other hospitals, trauma centers, and trauma patients

   - **Specialty Services Provided:** Neurosurgery, obstetrics, bum center, pediatric critical care etc., and the next nearest availability

   - **Patient Volume:** Number of patients annually, both 9-1-1 transports and walk-ins

   - **Notification of the Public:** Process to be used: public hearing, advertising, etc.; ensure that all appropriate health care providers are consulted with

   - **Availability of Prehospital Care:** Availability of ALS level prehospital care and air ambulance resources

   - **Public and Emergency Provider Comments:** Obtained through local EMS committees and public hearing

   - **Recommendations:** Shall include a determination of whether the request for reduction or elimination of emergency services should be approved or denied

4. Within sixty (60) days of notification, ICEMA shall:

    a. Ensure planning or zoning authorities have been notified

    b. Conduct at least one public hearing on the proposed changes.

    c. Submit an impact evaluation report to the local Emergency Medical Care Committee and the ICEMA Governing Board for approval

5. If ICEMA determines that additional time is needed to allow for EMS system reconfiguration or planning to occur in order to accommodate the license change requested by the hospital, a written request for up to an additional 60-calendar day delay in responding to the hospital's application may be requested by ICEMA and shall be considered by Licensing and Certification.

6. If ICEMA determines that approval of the downgrade or closure of the facility would have either no impact or a negligible impact on the EMS system, a written statement to that effect shall be submitted.

7. If ICEMA determines that the down-licensing or closure of a hospital emergency department or the closing of obstetrical, neurosurgical, burn services, or neonatal intensive care units will significantly impact the EMS system, ICEMA shall establish the reason or reasons a hospital has applied to do so and shall attempt to determine whether any system changes may be implemented to either maintain the hospital service within the system or develop strategies for accommodating the loss of the emergency department, or other identified specialized service to the system.

BASE HOSPITAL SELECTION CRITERIA

DEFINITION

A hospital or hospitals under contract with ICEMA authorized and responsible for the direct supervision by an Emergency Department physician or Mobile Intensive Care Nurse (MICN) of certified Emergency Medical Technician-Paramedic (EMT-P's) caring for patients while at the scene
of an emergency, during transport to a general acute care hospital, during interfacility transfer of patients, and while the EMT -P is caring for patients in a general acute care hospital during training or continuing education.

The local EMS Agency will utilize the following criteria for the selection and designation of Base Hospitals:

1. The Medical Director of ICEMA or the designee shall evaluate existing and potential Base Hospitals, following the criteria established and recommended to the Medical Director of ICEMA. All hospitals desiring potential Base Hospital designation must submit a request in writing to ICEMA expressing their desire to be evaluated and documenting adherence and acceptance of the requirements as outlined in this document.

2. **Minimum Requirements**
   a. Be licensed by the State Department of Health Services as a general acute care hospital.

   b. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations.

   c. Have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5, or have been granted approval by the Authority for utilization as a Base Hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code.

   d. Have a written agreement with ICEMA indicating the concurrence of hospital administration, the medical staff, and the Emergency Department staff, to meet the requirements for program participation as defined in Division 2.5 of the California Health and Safety Code, and ICEMA.

   e. Agree to abide by the letter and intent of Division 2.5 of the California Health and Safety Code, and/or subsequently chaptered laws of the State of California, and criteria established by ICEMA.

f. Accept such treatment guidelines for Advanced Life Support (ALS) procedures as may be developed and implemented by ICEMA.

g. Agree to acquire, utilize and maintain two-way telecommunications equipment as specified by ICEMA, capable of direct two-way voice communication with ALS field units assigned to the hospital. (This may include monetary contributions to a communications fund to maintain BASE HOSPITAL repeaters, etc.)

h. Maintain written policies and procedures pertinent to the EMS Program within the Emergency Department with documentation that these policies and procedures were reviewed and approved by the hospital's Interdisciplinary Committee.

i. Agree not to transfer from one hospital to another any patient who has been treated by an EMT -P unless or until, in the judgment of the Base Hospital Emergency Department physician, such a patient is medically stable to be transferred and/or such transfer is in the best interest medically of the patient. Such transfers must be accepted by the receiving hospital in accordance with JCAHO, Title 22 and ICEMA policies and procedures.

j. Agree to maintain the ReddiNet system providing the necessary ICEMA required documentation.

k. Notwithstanding the hospital's capabilities to comply with the provisions of these criteria, ICEMA shall designate Base Hospitals only after considering the overall objectives to minimize duplication of elements of the EMS System that result in needless expenditure of health care or associated resources.

OPERATING PRINCIPLES

1. **The following principles shall guide coordination of Base Hospital components of the local EMS System:**

   a. The Medical Director of ICEMA may update Base Hospital criteria as necessary.

   b. No Base Hospital shall advertise that it is a Base Hospital, nor shall it use its Base Hospital designation *for* the purpose of circumventing effective and efficient patient flow patterns.

   c. Patient designation will be directed by the Base Hospital Emergency Department physician, or the MICN in conjunction with the Base Hospital Emergency Department physician **(unless otherwise requested by the patient or the patient's family).**

   d. It is the responsibility of the Base Hospital Emergency Department physician or MICN to contact the receiving hospital ED physician/nurse as soon as possible during the direction of ALS intervention to provide the receiving hospital with information regarding patient condition and ALS interventions, when the ALS

provider is unable themselves to do so due to time constraints, patient condition, radio communication failure.

e. The attending physician at the receiving hospital where a patient is transported may request copies of voice records maintained on a patient by the Base Hospital. The request must be in writing.

2. **Quality Control and Evaluation:**

The hospital must:

a. Cooperate with and assist the Medical Director of ICEMA in data collection and evaluating performance and cost effectiveness of the EMS System. All ALS level calls must be logged and the logs kept for review. All ALS level calls must be recorded, and those recordings kept for a minimum of seven (7) years (or one year past the age of majority) along with copies of the Prehospital Patient Record and the MICN Prehospital Record.

b. Agree to maintain and make available to ICEMA any and all relevant records for program monitoring and evaluation of the ALS System.

c. Permit and assist in the announced and/or unannounced survey/inspection of facilities, records and staff at reasonable times, by the Medical Director of ICEMA, or his designee.

d. Be evaluated at least every two (2) years or as determined necessary by the Medical Director of ICEMA or his designee.

e. Abide by criteria established by ICEMA. Implementation of revised criteria must specify implementation dates and/or deadlines.

3. **Staffing:**

The hospital must:

a. Have in-house emergency physician coverage available twenty-four (24) hours per day, seven (7) days per week. The physician must be currently licensed in the State of California, assigned to the Emergency Department, available at all times to provide immediate medical direction to the MICN or ALS personnel. The physician must have experience in and knowledge of base hospital radio operations and ICEMA policies, procedures and protocols. All ED physicians must maintain current ACLS certification.

b. Have at least one (1) certified Mobile Intensive Care Nurse (MICN) or ED physician on duty in the Emergency Department, the majority of the time. ICEMA strongly encourages at least one (1) MICN on duty at all times. **(ICEMA must be notified in the event that 24-hour coverage by at least one (1) MICN is not provided, to assure that nurses giving direction to ALS personnel are trained and certified as MICNs by the local EMS Agency.)**

c. Have a full-time physician Director of the Emergency Department who is currently licensed in the State of California, who is certified or prepared for certification by the American Board of Emergency Medicine, a physician on the hospital staff, experienced in emergency medic al care, and be regularly assigned to the Emergency Department. In addition, this physician shall document experience in and demonstrate knowledge of Base Hospital radio operations and local EMS Agency policies and procedures, and shall be responsible for overall medical control and supervision of the EMT-P Program with the Base Hospital's area of responsibility, including review of Prehospital Patient Care Records with personnel involved. The Base Hospital Medical Director shall be responsible for reviewing on a monthly basis, the Prehospital Patient Care Records supplied through the QI process for all patients that are not transported to a general acute care hospital. Documentation of conclusions reached as a result of this review must be submitted to ICEMA monthly. The Base Hospital Medical Director shall be responsible for reporting deficiencies in patient care to the local EMS Agency.

(The hospital may designate a Prehospital Liaison Physician who is a physician currently licensed in the State of California, and is regularly assigned to the ED to assist the Base Hospital Medical Director to fulfill the aforementioned responsibilities to the local EMS System.)

d. Identify a MICN with experience in and knowledge of Base Hospital radio operations and local EMS Agency policies and procedures as a Prehospital Liaison Nurse (PLN) to assist the Base Hospital Medical Director and/or the Prehospital Liaison Physician in the medical control and supervision of ALS personnel.

4. **Continuing Education and In-service Training**:

The hospital must:

a. In cooperation with other hospitals, training institutions, ICEMA, and ALS providers provide continuing education for physicians, MICNs and other ALS field personnel in accordance with the criteria established by the local EMS Agency.

b. Provide supervised clinical training for both ALS students as well as currently certified ALS personnel assigned to that Base Hospital.

c. In cooperation with other hospitals and ALS providers, provide for organized field audits in accordance to the ICEMA QI Plan for MICNs and other certified personnel in order to review field care and improve field operations. These field audits must be in accordance with the criteria established by the ICEMA QI Plan.

d. Provide monthly Base Hospital meetings for the purpose of reviewing field care and/or providing didactic continuing education approved by ICEMA.

e. Provide orientation regarding the EMS System to appropriate hospital employees. Insure that ED personnel are involved both as instructors and as students in continuing education and In-service Programs.

5. **General**

The hospital must:

a. Provide regularly scheduled ED physician and nurse meetings to discuss ED responses and care.

b. Insure that there is a liaison between hospital personnel and Prehospital Care Personnel (PLN or ED Medical Director).

c. Establish and implement an internal system for critiquing the results of ALS intervention while auditing the quality of care provided.

d. Provide a statement describing committee representation and attendance to all ICEMA required Physician and Nurse Committee Meetings (Base Hospital QI Meetings, EMS Nurses, ED Physicians, etc.).

e. Coordinate and cooperate with designated receiving hospitals in accordance with guidelines implemented by ICEMA.

6. **It is the responsibility of the Base Hospital Medical Director and/or the ED Nursing Supervisor to notify the Medical Director of ICEMA of any deviation from the aforementioned Base Hospital criteria.**

7. **Suspension and/or Revocation of Base Hospital Designation**

ICEMA may suspend or revoke the approval of a Base Station Hospital at any time for failure to comply with the applicable policies, procedures and regulations.

BASE HOSPITAL CRITERIA FOR DESIGNATION OF HOSPITAL LICENSED AS STAND-BY - MONO COUNTY

"BASE HOSPITAL" upon designation by the local EMS Agency and upon completion of a written contractual agreement with the local EMS Agency, is responsible for directing the Advanced Life Support System or Limited Advanced Life Support System and prehospital care system assigned to it by the local EMS Agency.

The Base Hospital will supervise prehospital treatment, triage advanced life support transport/limited advanced life support transport, and monitor personnel program compliance by direct medical supervision for ALC/LALS unit providing services in Mono County.

The designation as a Base Hospital shall be for no longer than two years.

SCOPE OF SERVICES TO BE PROVIDED

The Base Hospital responsibilities shall include, but not be limited to the following:

1. Orientation of entire Base Hospital staff to ALS/LALS program.

2. Formation and/or continuation of network with associated receiving hospital in the region.

3. On-line medical direction for treatment, triage and transport of ALS/LALS patients according to ICEMA protocol.

4. Transmission of patient care information on each ALS/LALS run to associated receiving hospital via direct dial or dedicated phone line.

5. Weekly case review by the Base Hospital Medical Director and Prehospital Liaison Nurse.

6. Provision of monthly case review conference for prehospital and hospital team, and regular in-hospital clinical experience.

7. Maintenance of EMS system's records including patient care and paramedic/EMT-II competency files.

8. Training of new EMS personnel through monitoring field performance and direct observation through ride along.

9. Stocking and restocking ALS/LALS unit with supplies and drugs in accordance with ICEMA policies.

HOSPITAL EMERGENCY MEDICAL SERVICES

1. Scope of services to be offered:

a. Include appropriate policies and procedures

b. Include By-Laws, vitaes and job descriptions

2. Agreement to provide ICEMA with data compatible with existing base hospital data collection and future data collection requirements established either by ICEMA or the state EMS Authority.

3. Policy for billing receiving centers to recover cost of supplies and drugs distributed to ALS/LALS units.

4. Letter of commitment to meet present and future Base Hospital requirements and maintain records.

5. Hospital policy and procedures regarding Quality Assurance Audit of ALS/LALS Unit Personnel and Medical Control Personnel Duties.

PROVISIONS APPLICABLE TO CONTRACT FOR BASE HOSPITAL SERVICES IN MONO COUNTY UTILIZING LICENSED STAND-BY FACILITY.

1. Status of Provider/Contractor

The provider shall be an independent contractor, wholly responsible for the manner in which it performs and will assume exclusively the responsibility for the acts of its employees who will not be entitled to any rights and privileges of ICEMA employees nor be considered in any manner to be ICEMA employees.

2. Services

The provider shall maintain facilities and equipment and operate continuously with at least the number and kind of staff required for the provision of services. Such services shall include at least those described in "Scope of Services" above.

3. Licenses and Standards

The provider's personnel shall possess appropriate licenses and certificates and be qualified in accordance with applicable statutes and regulations. The provider shall obtain, maintain, and comply with all necessary governmental authorizations, permits and licenses required to conduct its operations. In addition, the provider shall comply with all applicable Federal, State and ICEMA policies and procedures, rules, regulations, and orders in its operations including compliance with all applicable safety and health requirements as to provider's employees.

MINIMUM REQUIREMENTS

1. Be licensed by the State Department of Health Services as a general acute care hospital.

2. Be accredited by the Joint Commission of Accreditation of Hospitals.

3. Have a special permit for Stand-by Emergency Medical Service.

4. Have a written agreement with ICEMA indicating the commitment of hospital administration, the medical staff, and the Emergency Department staff, to meet the requirements for program participation as defined in Division 2.5 of the California Health and Safety Code, and ICEMA.

5. Agree to abide by the letter and intent of Division 2.5 of the California Health and Safety Code, and/or subsequently chaptered laws of the State of California, and criteria established by ICEMA.

6. Accept such treatment guidelines for prehospital procedures as may be developed and implemented by ICEMA.

7. Agree to acquire, utilize and maintain communications equipment as specified by ICEMA capable of direct two-way voice communication with prehospital field units assigned to the hospital.

8. Maintain written policies and procedures pertinent to the EMS Program within the Emergency Department with documentation that these policies and procedures were reviewed and approved by the hospital's Medical Staff Committee.

9. Agree not to transfer from one hospital to another any patient who has been treated by an EMT-P or EMT-II unless or until, in the judgment of the Base Hospital Emergency Department physician, such a patient is medically stable to be transferred and/or such transfer is in the best interest medically of the patient. Such patients must be accepted by the receiving hospital in accordance with JCAHO and Title 22.

OPERATING PRINCIPLES

1. The following principles shall guide coordination of Base Hospital components of the local EMS System:

    a. The Medical Director of ICEMA may update Base Hospital criteria as necessary.

    b. No Base Hospital shall advertise that it is a Base Hospital, nor shall it use its the purpose of circumventing effective and efficient patient flow patterns.

    c. Patient designation shall be directed by the Base Hospital physician, or MICN in conjunction with the Base Station physician, unless otherwise requested by the patient or the patient's family.

d. MICN standing orders shall be developed by the Base Hospital and approved by ICEMA.

e. It is the responsibility of the Base Hospital Emergency Department physician or MICN to contact the receiving hospital ED physician or nurse as soon as possible during the direction of ALS/LALS intervention to provide the receiving hospital with information regarding patient condition and ALS/LALS interventions.

f. The attending physician at the receiving hospital where a patient is transported may request copies of voice and records maintained on a patient by the Base Hospital. The request must be in writing.

g. The Base Hospital shall insure that a mechanism exists for the initial supply of pharmacological agent (including narcotics and controlled substances) to be utilized by ALS/LALS field personnel during the treatment of patients according to policies and procedures established by ICEMA.

QUALITY CONTROL AND EVALUATION

The hospital shall:

1. Cooperate with and assist the Medical Director (If ICEMA in data collection and performance and cost effectiveness of the EMS system. All ALS/LALS level calls must be logged and log kept for review. All ALS/LALS level calls must be recorded, and those recordings kept for a minimum of seven (7) years (or one year past the age of majority) along with copies of the Prehospital Patient Record and the MICN Prehospital Record.

2. Agree to maintain and make available to ICEMA any and all relevant records for program monitoring and evaluation of the ALS/LALS System.

3. Permit and assist in the announced and/or unannounced survey/inspection of facilities, records and staff at reasonable times, by the Medical Director of ICEMA or his designee.

4. Be evaluated at least every two (2) years and as needed by the Medical Director of ICEMA or his designee.

5. Abide by criteria established by ICEMA. Implementation of revised criteria must specify implementation dates and/or deadlines.

STAFFING

The hospital shall:

1. Have Emergency Physician coverage immediately available twenty-four (24) hours per day, seven (7) days per week. Immediately available means available in the Emergency Department within twenty (20) minutes upon notification.

The physician must be currently licensed in the State of California, assigned to the Emergency Department, available at all times to provide immediate medical direction to the MICN or ALS/LALS personnel when situation not covered by MICN Standing Orders. Hospital policy for providing immediate medical control when the ED Physician is not inhouse must be submitted to ICEMA for approval.

All ED Physicians must maintain current ACLS Certification and be knowledgeable in radio operations and current policies.

2. Have a full-time physician Director of the Emergency Department who is currently licensed in the State of California, a physician on the hospital staff, experienced in emergency medical care, and regularly assigned to the Emergency Department. This physician Director shall have experience in and knowledge of Base Hospital radio operations and ICEMA policies and procedures, and shall be responsible for overall medical control and supervision of the EMT-P/EMT-II program within the Base Hospital's area of Responsibility, including review of Prehospital Patient Care Records and critique with personnel involved. The physician Director shall be responsible for reviewing on a monthly basis, the Prehospital Patient Care Records for all patients that are not transported to a general acute care hospital. Documentation of conclusions reached as a result of this review must be submitted to ICEMA monthly. The physician Director shall be responsible for reporting deficiencies in patient care to ICEMA.

   Physician Director to fulfill the aforementioned responsibilities.

3. Have at least one (1) Mobile Intensive Care Nurse (MICN) or ED physician on duty in the hospital assigned to the radio communications center and readily available to the Emergency Department. In the event that an ED physician is not on duty, there shall be immediately available direct voice contact with ALS/LALS personnel by the ED physician for the purposes of medical control. ICEMA must be notified in the event that 24-hour coverage by at least one (1) MICN is not provided. Nurses giving direction to ALS/LALS personnel must be trained and certified as MICN's by ICEMA.

4. Identify a MICN with experience in and knowledge of Base Hospital radio operations and ICEMA policies and procedures as a Prehospital Liaison Nurse (PLN) to assist the physician director in the medical control and supervision of ALS/LALS personnel.

CONTINUING EDUCATION AND IN-SERVICE TRAINING

The hospital shall:

1. In cooperation with other hospitals, training institutions, ICEMA and ALS/LALS providers, provide continuing education for physicians, MICN's and field personnel in accordance with criteria established by ICEMA.

2. Provide supervised clinical training for both ALS/LALS students, as well as currently certified ALS/LALS personnel assigned to that Base Hospital.

3. In cooperation with other hospitals and ALS/LALS providers, provide for organized field audits at least six (6) times annually for MICN's and other certified personnel in order to review field care and improve field operations. These field audits must be in accordance with the criteria established by ICEMA.

4. Provide monthly Base Hospital meetings for the purpose of reviewing field care and/or providing didactic continuing education approved by ICEMA.

5. Provide orientation regarding the EMS System to appropriate hospital employees.

6. Insure that ED personnel are involved both as instructors and as students in continuing education and In-service Programs.

GENERAL

The hospital shall:

1. Provide regularly scheduled ED physician and nurse meetings to discuss ED responses and care.
2. Insure that there is a liaison between hospital personnel and the prehospital care personnel.

3. Establish and implement an internal system for critiquing the results of ALS/LALS intervention while auditing the quality of care provided.

4. Designate committee representation to ICEMA. Regular attendance at Physician and Nurse Committee meetings is mandatory.

5. Coordinate and cooperate with designated receiving hospitals in accordance with guidelines implemented by ICEMA.

IT IS THE RESPONSIBILITY OF THE BASE HOSPITAL MEDICAL DIRECTOR AND/OR THE ED NURSING SUPERVISOR TO NOTIFY THE MEDICAL DIRECTOR OF ICEMA OF ANY DEVIATION FROM THE AFOREMENTIONED CRITERIA.

ICEMA MAY SUSPEND OR REVOKE THE APPROVAL OF A BASE HOSPITAL AT ANY TIME FOR FAILURE TO COMPLY WITH THE APPLICABLE POLICIES, PROCEDURES AND REGULATIONS.

REVIEW OF POLICIES AND PROTOCOLS

I. PURPOSE

To establish procedures for the review of EMS system policies and patient care protocols.

The ICEMA Medical Director and EMS Administrator are responsible for the development and approval of policies and protocols that establish operating procedures and medical control according to State regulations. ICEMA recognizes that stakeholder collaboration is an essential component of policy and protocol development and accepts input from the Medical Advisory Committee (MAC), System Advisory Committee (SAC), standing ICEMA subcommittees and/or other interested parties through a review process as established below. EMS stakeholder input is advisory to ICEMA for the formulation of these policies, protocols and procedures and the final authority rests with the ICEMA Medical Director and EMS Administrator.

II. DEFINITIONS

Medical Advisory Committee (MAC): Primary committee that advises the ICEMA Medical Director on the clinical or medical aspects of Emergency Medical Services (EMS) within the ICEMA region.

Patient Care Protocols: Medical standards that provide the framework for the medical treatment and care routinely provided to patients within the ICEMA region.

EMS System Policies: EMS system organization, principal functions and mode of operations for providers and healthcare facilities within the ICEMA region that guide EMS system operations.

System Advisory Committee (SAC): Primary committee that advises the ICEMA EMS Administrator on the operational aspects of EMS within the ICEMA region.

III. POLICY

- ICEMA will review all EMS system policies and patient care protocols, as necessary, to ensure time critical and appropriate changes.

- ICEMA will solicit input from appropriate external agencies, organizations and established advisory committees such as those listed below, as necessary:

  - Medical Advisory Committee (MAC)

- ➢ System Advisory Committee (SAC)
- ➢ ST Elevation Myocardial Infarction QI Committee (STEMI QI)
- ➢ Neurovascular Stroke QI Committee (Stroke QI)
- ➢ Trauma Advisory Committee (TAC)
  (Joint San Bernardino County and Riverside County Quality Improvement Committee).

- ICEMA will review EMS system policies and patient care protocols as required. Changes that may occur without specific input from committees include, but are not limited to:
  - ➢ Changes in wording necessary to clarify the objective.
  - ➢ Changes in the listed order or numbering necessary for clarity or flow.
  - ➢ Changes to assure policy or protocol continuity and consistency.
  - ➢ Changes required to comply with State and local laws and/or regulations to maintain public health and safety.
  - ➢ Correction of typographical, grammar, spelling or formatting errors.
  - ➢ Changes required for medical control or to maintain system integrity.
- ICEMA will prepare a detailed grid of proposed policy and protocol changes for input from MAC and SAC.
- ICEMA will consider all relevant input presented to it before accepting, amending or deleting any EMS system policy or treatment protocol, but the authority for final determination remains with the Medical Director and EMS Administrator.
- ICEMA will submit changes in EMS system policies and patient care protocols to public comment as noted below under Section VI - Notification and Public Comment Period.
- EMS system policies and patient care protocols, approved by the Medical Director and EMS Administrator, shall become effective no later than thirty (30) days after the date of approval except as noted under Section V - Emergency Policies and Protocols.

IV. REQUEST FOR REVIEW OF EMS SYSTEM POLICIES/PATIENT CARE PROTOCOLS

- Any interested party may request the review of EMS system policies or patient care protocols as provided in this section. Such requests shall be in writing and clearly and concisely state:

  - The substance or nature of the requested review.

  - The reason for the request.

  - Any supporting documentation and/or research that would support the request.

- Upon receipt of a written request for the review of a policy or protocol, ICEMA will notify the petitioner or group in writing of the receipt of the request and then shall, within thirty (30) business days, either deny the request, in writing, indicating why the agency has reached such a decision or schedule the policy or protocol for review, in the appropriate committee(s), in accordance with this policy.

- ICEMA may grant or deny such a request or take such other action as it may determine to be warranted and will notify the petitioner in writing of such action.

V. EMERGENCY POLICIES AND PROTOCOLS

- If ICEMA determines that an emergency policy or protocol is necessary for the immediate preservation of the public health and safety or general welfare, a policy or protocol may be changed as an emergency action.

- Any finding of an emergency will include a written statement describing the specific facts showing the need for immediate action. The statement and the policy or protocol shall be immediately forwarded to MAC and/or SAC and EMS providers (as appropriate). The emergency policy or protocol will become effective no sooner than five (5) days following dissemination to the committee, unless there is an immediate need determined by ICEMA.

- Policies or protocols adopted under the emergency provision shall remain in effect until reviewed by the appropriate committee.

VI. NOTIFICATION AND PUBLIC COMMENT PERIOD

Consistent with a policy of encouraging the widest possible notification and distribution to interested persons, ICEMA will:

- Post proposed changes to policies or protocols on the ICEMA website at ICEMA.net at least thirty (30) days prior to the MAC and/or SAC meetings. The notice of change will include a statement of the time and place of proceedings for public comment.

- E-mail notification of proposed changes to members of the Emergency Medical Care Committee (EMCC), MAC and SAC.

- E-mail notification of proposed changes to each EMS provider.

- E-mail notification of proposed changes to any person who has filed a request for notification with ICEMA.

- Conduct official public comment during the MAC and/or SAC meeting.

The provisions of this section shall not be construed in any manner to invalidate a protocol or policy due to perceived inadequacy of the notice.

When necessary to fulfill its responsibilities, ICEMA will revise and/or initiate policies or protocols without following this process. Any oversight in notification described above shall not invalidate any action taken by ICEMA pursuant to this policy.

RADIO COMMUNICATION POLICY

I. PURPOSE

To define the requirements for communication reports between EMS field personnel and hospitals. The purpose of communication between EMS field personnel and hospitals is to relay essential information to allow the hospital to prepare for the patient, and as necessary, to allow a base hospital to provide medical control and consultation to the EMS field personnel.

II. PROCEDURE

A. General Guidelines

- The communication report should be brief, concise, and include only the information that impacts the care of the patient in the field, and when the patient initially arrives in the hospital.
- It should not include unnecessary information, or impede the EMS field personnel's focus on patient care.
- The communications report is not intended to be the complete patient report nor is it equivalent to the "face-to-face" report to the Emergency Department (ED) staff at the hospital.
- Communication reports should be given to the hospital by EMS field personnel while on scene, or as soon as possible after departing the scene.
- Transport of unstable patients or patients meeting Trauma Triage Criteria shall not be delayed for a communications report.
- EMS field personnel may only accept orders from base hospitals within the ICEMA region.
- Patient names shall not be given over the radio except at the request of the base hospital physician, and with the prior approval of the patient.
- Base hospital physicians may give any medically appropriate order within the EMS field personnel's scope of practice.

B. Basic Life Support (BLS) Units

BLS communication reports contain minimal information since BLS units:

- Cannot be diverted; and
- Cannot carry out medical control orders.

BLS communications reports contain:

- The EMS unit identifier, and that it is a BLS report;
- The patient's age, sex, chief complaint/injury, and estimated time of arrival (ETA);
- Vital signs, Glasgow Coma Scale, and other pertinent signs/ symptoms and information.

C. Advanced Life Support (ALS) Units

Receiving Hospital:

Receiving hospital communication reports are for informing the receiving hospital (base hospital or otherwise) of incoming patients **not** requiring medical control orders or consultation.

Receiving hospital communications reports contain:

- The EMS unit identifier, that it is a receiving hospital report, and the EMS field personnel's name/certification level;
- The patient's age, sex, chief complaint/injury and ETA;
- Information that impacts patient care.

Base Hospital:

Base hospital communication reports are for:

- Requesting consultation or medical control orders from a base hospital;
- Informing or consulting with a specialty base hospital (Trauma, STEMI, stroke center, etc.).

- Patients receiving ALS interventions:
  - Who do not improve; or
  - Who are not being transported by ambulance; or
  - Prior to terminating resuscitative efforts.
  - Unsuccessful procedures per ICEMA Reference #10190 - Procedure - Standard Orders.
- All patients under nine (9) years old that are not transported by ambulance (parent or guardian refusal). Base hospital contact shall be made while the EMS field personnel is on scene (if safe) per ICEMA Reference #9080 - Care of Minors in the Field.
- Interfacility transfers needing medications and/or a destination change per ICEMA Reference #8010 - Interfacility Transfer Guidelines.
- Multi-Casualty Incidents (MCI) per ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident.

Base hospital communications reports shall contain:

- The EMS unit identifier, that it is a base hospital report, and the EMS field personnel's name/certification level;
- The severity of the patient, and if the patient is a "specialty care" patient (Trauma, STEMI, stroke, etc.);
- Patient age, sex, general appearance, weight in kilos, and level of responsiveness (or Glasgow Coma Scale when appropriate);
- Chief complaint/injuries, and mechanism of injury/patient situation;
- Vital signs, cardiac monitor reading, and remarkable physical exam findings;
- Pertinent medical history;
- Prior to contact treatment initiated and patient response;
- Information that impacts patient care;
- ETA.

Base hospitals will provide:

- Contact time, and the name of the Mobile Intensive Care Nurse (MICN) (and base hospital physician when present).

- Consultation and medical control orders appropriate to the patient condition.

- Acknowledgement of prior to contact medications and patient response.

D. <u>EMS Aircraft Transports</u>

In San Bernardino County, the San Bernardino County Communications Center (Comm Center) will assign the destination hospital for trauma patients when a request for EMS aircraft is received.

- When possible, Comm Center will notify the ground and air transportation provider of the assigned destination hospital.

- Trauma base hospital contact should be made as soon as practical by the ground EMS field personnel or the flight crew.

- Whenever possible, **Trauma base hospital contact will be made with the Trauma Center that will actually be receiving the patient.**

- Upon arrival of the EMS aircraft, the ground EMS field personnel will give a patient report to the flight crew, and include:

  - The assigned destination hospital (if known);

  - If Trauma base hospital contact has been made (and with which Trauma base hospital); and

  - If the assigned destination hospital was changed (and the reason for the change).

- The flight crew will contact the actual receiving Trauma Center to:

  - Request a landing pad assignment;

  - Provide a patient report, or update on patient condition; and

  - Inform them if Trauma base hospital contact was originally made with a different Trauma base hospital.

If the original Trauma base hospital contact was made with a different Trauma base hospital, the actual receiving Trauma Center will notify the original Trauma Base of the change in destination.

E. Interfacility Transfer (ICEMA Reference #8010 - Interfacility Transfer Guidelines)

Interfacility transport patients with a deteriorating condition significant enough to require medication administration and/or a destination change require base hospital contact.

- EMS field personnel may initiate prior to contact protocols, and shall make base hospital contact. The base hospital will be notified of the status change of the patient, the medications administered prior to contact and any need for further orders or destination changes.

- The base hospital shall notify both the referral hospital and the original receiving hospital of a destination change.

- The base hospital will include an evaluation of any destination change in the base hospital CQI report.

III. REFERENCES

Number	Name
5050	Medical Response to a Multi-Casualty Incident
8010	Interfacility Transfer Guidelines
9080	Care of Minors in the Field
10190	Procedure - Standard Orders

MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT

PURPOSE

To outline and coordinate the responses by EMS system participants to Multi-Casualty Incidents (MCI) and to standardize definitions, as outlined in the Firescope Field Operations Guide (FOG) and the responsibilities of each participating entity.

PRINCIPLES

1. Field responses to a MCI will follow the procedures/guidelines consistent with the Incident Command System (ICS) as outlined in Firescope.

2. Hospitals shall receive as much advanced notice as possible to prepare for arriving patients.

SCOPE

A MCI is any incident where personnel on scene have requested additional responses to care for all victims.

- Incident requires five (5) or more ambulances; and/or
- Incident involves ten (10) or more patients; and/or
- Requires utilization of triage tags; and/or
- May require patient distribution to more than one (1) hospital.

PROCEDURE

General Operational Procedures

1. First arriving resource with the appropriate communications capability shall declare an MCI; establish command, name the incident and request hospital bed availability through the Coordinated Communication Center (CCC). This resource shall remain in command until relieved by the public safety agency having jurisdictional authority.

2. All operation functions and procedures on scene will be in accordance with Firescope.

3. The Incident Commander (IC) will assign the first available resource to triage. Adults shall be triaged according to START as outlined in Firescope. Pediatric patients shall be triaged according to JumpSTART (see definitions) developed by California Emergency Medical Services for Children.

4. The IC or designee shall establish communications with the CCC on the Med Comm Talk Group for situation update and to obtain hospital bed availability.

5. The Medical Communications Coordinator (Med Comm), when initially communicating with the CCC, will provide the following information:

   Name of Incident type, location and agency in charge.

6. Patients should generally be transported to the appropriate hospitals as provided to the Med Comm by the CCC.

7. The Med Comm shall notify the CCC with the following information for all patients departing the scene:

   a. Transport method (air, ground, bus)

   b. Transport agency and unit

   c. Number of patients (adult and pediatric)

   d. Classification of patients (Immediate, Delayed, Minor)

   e. Destination (in accordance with CCC destination availability)

8. Transporting units shall make attempts to contact the receiving hospital enroute to provide patient(s) report using the incident name to identify the patient and provide the following information:

   a. Incident name

   b. Transporting agency and unit number

   c. Age/sex

   d. Mechanism of injury

   e. Chief complaint and related injuries that may need specialty services, e.g. respiratory, neuro, vascular or decontamination

   f. Glasgow Coma Scale

   g. ETA

9. If the destination is changed en route from that provided by the Med Comm, the transporting unit shall notify the CCC through its dispatch and shall make contact to revised receiving hospital. The CCC will notify the original destination that the transporting unit has been diverted by the base station physician or that the patient condition has deteriorated.

Special Operational Procedures - Use of Non-Emergency Vehicles

The Patient Transportation Unit Leader (PTUL), in coordination with the IC, may utilize non-emergency vehicles to transport patients triaged as "minor." The Med Comm will work with the receiving facilities to coordinate the destinations. In such cases, the following conditions shall apply:

1. Non-emergency vehicles may be requested through the CCC or by special arrangement made on scene by the PTUL; however, in the event arrangements are made on scene, the PTUL shall notify the CCC.

2. If resources allow at least one ALS team (minimum of one paramedic and one EMT) with appropriate equipment will accompany each non-emergency transport vehicle.

3. Generally, the ratio of patients to ALS team should not exceed 15:1.

4. In the event of deterioration of a patient enroute, the non-emergency unit shall immediately call for an ALS emergency ambulance and transfer care for transport to the closest emergency department.

Responsibilities of the County Communications Center (CCC)

1. Upon field notification of an MCI, the CCC shall immediately poll hospitals via the ReddiNet for bed availability.

2. The CCC shall advise other 9-1-1 dispatch centers of the MCI, including the name and location.

3. The CCC shall dispatch all air resources for the MCI.

4. The CCC shall notify the EMS Agency when five or more ambulances are requested.

5. The CCC will confirm patient departure from scene with Med Comm by providing the departure time.

6. The CCC will advise receiving hospitals of the number/categories of patients en route via ReddiNet or other approved method.

7. The CCC will notify all involved hospitals when the MCI is concluded.

Responsibilities of the Receiving Hospital

1. All hospitals shall respond immediately to the ReddiNet poll.

2. A receiving facility may not change the destination of a patient.

3. A designated Trauma Hospital Base Station physician may change a patient destination only if a patient condition deteriorates.

4. Hospitals shall enter all required information into the ReddiNet, including, but not limited to, names, age sex and triage tag number of patients transported from the MCI.

5. Each hospital that received patients from the MCI shall participate in after action reviews as necessary.

Medical Control

1. EMS personnel shall operate within ICEMA "prior to contact" protocols for both medical and trauma patient(s).

2. If base station consultation is necessary, medical control refers to a specific patient(s) and not to the incident as a whole (operational aspects).

Field Documentation

1. The Med Comm maintains responsibility to ensure the following:

    a. Utilization of the Med Com log. This form will include:

        i. Name and location of the Incident

        ii. Triage tag number for each patient and their hospital destination

        iii. Brief description of the Incident

    b. Completion of as much information a available will be documented on the triage tag.

    c. A completed individual patient care report for all patients with a chief complaint who "refuse treatment" and desire to sign a release of liability or AMA.

2. Each transporting unit is responsible for generating a patient care report for each patient transported excluding patients transported by non-emergency vehicles. Those transported in non-emergency vehicles will be identified by triage tags. This should include patient tracking tag/number and will indicate the incident name and location.

ADDENDUM

Firescope Operations Procedures of a Multi-Casualty Incident

Operational System Description

The Multi-Casualty organizational module is designed to provide for the necessary supervision and control of essential functions required during a Multi-Casualty Incident. The primary functions will be directed by the Medical Group Supervisor, if activated (or Operations), who reports to the Multi-Casualty Branch Director, if activated, or in most cases, the Incident Commander. Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The Medical Branch structure in the ICS system is designed to provide the Incident Commander with a basic, expandable modular system for managing the incident. The system is designed to be set up consistent in all incidents involving mass casualties and has the ability to expand the incident organization as needed.

Initial Response Organization: Initial response resources are managed by the Incident Commander, who will handle all Command and General Staff responsibilities. The resources will respond based on the **operational procedures** (as outlined in this protocol).

Reinforced Response Organization: In addition to the initial response, the Incident Commander establishes a Triage Unit Leader, a Treatment Unit Leader, Patient Transportation Unit Leader and Ambulance Coordinator. Also patient treatment areas are established.

Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch may be designated to provide coordination between the Ambulance Coordinator and the Air Operations Branch. The Extrication Group is established to free entrapped victims.

Multi-Branch Incident Organization: The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals.

Operational Principles

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, name the incident, and request bed availability. This resource will remain in command until relieved by the public safety agency having jurisdictional authority.

2. The IC will assign the first available resource to triage. Victims shall be triaged according to START/JumpSTART criteria, and ICS shall be implemented according to Firescope.

3. The IC will assign the resource with the appropriate communications capability to establish communications with CCC situation update and to obtain bed availability.

4. Treatment areas are set up based upon needs and available resources according to classification of patients (immediate, delayed and minor.) The Treatment Unit Leader will notify Patient Transportation Unit Leader when a patient is ready for transportation and of any special needs (e.g. Burns, Pediatrics, etc.)

5. Patients are transported to the appropriate facilities based upon patient condition, bed availability, and transport resources. The Patient Transportation Unit Leader and the Medical Communications Coordinator will work together to transport the patients using the appropriate methods to the most appropriate destinations.

6. The Patient Transportation Unit Leader/Medical Communications Coordinator will determine all patient destinations.

7. The Incident Commander will designate a staging area (s). Transportation personnel should stay with their vehicle to facilitate rapid transport, unless reassigned by the Incident Commander or his designee.

8. The Patient Transportation Unit Leader will then call for an ambulance or other designated transportation vehicle to respond to the loading area.

9. The Patient Transportation Unit Leader, in coordination with the Incident Commander, may put in a request through the Communications Center for busses to transport minor or uninjured patients.

10. The Patient Transportation Unit Leader will copy the information from the triage tag onto a Patient Transportation Log, and confirm destination with the ambulance crew.

11. The Patient Transportation Unit Leader will notify Medical Communications Coordinator of patient departure.

12. The transporting unit should contact the receiving facility en route with a patient report, using the Incident name to identify the patient.

INYO AND MONO COUNTIES
MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT

PURPOSE

1. To outline and coordinate the responses by EMS system participants to Multi-Casualty Incidents (MCI) in Inyo and Mono Counties.

2. To standardize definitions, as outlined in the Firescope Field Operations Guide (FOG) and the responsibilities of each participating entity.

PRINCIPLES

1. Field responses to an MCI will follow the procedures/guidelines consistent with the Incident Command System (ICS) as outlined in Firescope.

2. Hospitals shall receive as much advanced notice as possible to prepare for arriving patients.

SCOPE

An MCI is any incident where personnel (law, fire, or medical) on scene have requested additional resources to care for all victims. This may include one or more of the following criteria:

1. An incident requiring three (3) or more ambulances and/or involving five (5) or more patients.

2. The utilization of triage (e.g. START) tags.

3. Patient distribution beyond one (1) hospital.

PROCEDURE

General Operational Procedures:

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource shall remain in command until relieved by the public safety agency having jurisdictional authority.

2. Sheriff's Office (SO) Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions) OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.

3. The first medical personnel (e.g. ambulance crew) on scene shall:

   a. Become the Medical Group Supervisor, and

   b. Initiate triage. Adults shall be triaged according to START as outlined in Firescope. Pediatric patients shall be triaged according to JumpSTART developed by California Emergency Medical Services for Children. Triage and patient tracking and coordination with receiving hospitals shall be accomplished utilizing standard triage tags.

   c. Assume responsibility for requesting additional resources (e.g. ambulances, personnel, equipment) in coordination with the base station, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and available and relevant (dependent on geographical location and availability and communications capability), and

   d. Assume responsibility for patient tracking and matching patient types/needs with appropriate and available transportation resources and staff and receiving hospitals, in coordination with the base station, SO and/or CHP Dispatch, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), and

   e. Contact base station and/or receiving hospitals and/or EMS aircraft providers for patient destination and coordination once the MCI has been declared.

4. All operation functions and procedures on scene will be in accordance with Firescope and National Incident Management System (NIMS).

5. The Medical Group Supervisor shall establish communications with the base station and/or receiving hospitals through available methods for situation update (i.e. Medical Sit Rep) and to obtain hospital bed availability/coordination, with the assistance and support of SO and/or CHP Dispatch, EMS aircraft providers, and the OES Operational Area Coordinators (fire, law, and/or MHOAC), as requested and relevant (dependent on geographical location and availability and communications capability).

6. The Medical Group Supervisor will identify and request the necessary resources through the IC or designee. The IC or Medical Group Supervisor will contact the base station and/or receiving hospitals and/or OES Mutual Aid Coordinators (fire, law, MHOAC), with the assistance and support of SO and/or CHP Dispatch, as available and appropriate, to fulfill medical resource requests.

7. During incidents with multiple destination hospitals, the Medical Group Supervisor may assign a Medical Communications Coordinator (Med Comm). The Med Comm will provide the following information when initially communicating with Dispatch (SO or CHP), the base station and/or receiving hospitals, or OES Mutual Aid Coordinators (fire, law, MHOAC):

    a. Name of incident, type, location, initial patient estimate and agency in charge.

    b. Patients should be transported to the appropriate hospitals as provided to the Med Comm by the Medical Group Supervisor.

8. The Medical Group Supervisor, shall notify the base station and the receiving hospital(s) (or Med Comm shall notify Dispatch, if available and assigned, to relay to the hospitals) (or EMS aircraft providers shall communicate with receiving hospitals) of the following information for all patients departing the scene:

    a. Transport method (e.g. air, ground, bus).

    b. Transport agency and unit.

    c. Number of patients (adult and pediatric).

    d. Identification (triage tag number) and classification of patients (i.e. Immediate, Delayed, Minor).

    e. Destination (only when Med Comm is coordinating multiple hospital destinations based on base station, EMS aircraft providers, and/or Medical Group Supervisor evaluation of hospital availability).

9. Transporting units shall make attempts by available means to contact the receiving hospital en route to provide patient(s) report using the incident name to identify the patient and provide the following information:

    a. Incident name.

    b. Transporting name and unit number.

    c. Age/sex.

    d. Illness or mechanism of injury.

    e. Triage classification (immediate (red), delayed (yellow), green (minor), and any significant deterioration in condition/status during transport.

f. Chief complaint and related illness/injury that may need specialty services, (e.g. respiratory, neuro, vascular, decontamination, burns).

g. Glasgow Coma Scale (GCS), if relevant.

h. Estimated Time of Arrival (ETA).

i. Tracking of patients and destinations is the primary joint responsibility of the base station and field medical personnel, with assistance as requested and available from the Dispatch.

If the destination is changed en route, the transporting unit shall notify the initial receiving hospital, if possible, and shall make attempts to contact the new receiving hospital en route. If the base station is coordinating patient destinations in conjunction with the Med Comm, the transporting unit will notify the base station, who will notify the original destination that the patient has been diverted by the base station physician or that the patient condition has deteriorated.

Special Operational Procedures - Use of Non-Emergency Vehicles:

The Medical Group Supervisor, in coordination with the IC, may utilize non-emergency vehicles to transport patients triaged as Minor (green). The Medical Group Supervisor (or Med Comm, if assigned) will coordinate the destinations with the base station and/or receiving hospitals, if there are multiple receiving facilities. In such cases, the following conditions shall apply:

1. Non-emergency vehicles may be requested through the IC, through Dispatch or by special arrangement made on scene by the Medical Group Supervisor.

2. If resources allow, at least one (1) ALS team (minimum of one (1) paramedic and one (1) EMT) with appropriate equipment will accompany each non-emergency transport vehicle. Generally, the ratio of patients to ALS team should not exceed 15:1.

3. When resources do not permit an ALS team to accompany a non-emergency transport vehicle, a BLS team consisting of at least two (2) EMT's and/or First Responders will accompany the vehicle. Generally, the ratio of patients to BLS team should not exceed 9:1.

4. In the event of deterioration of a patient en route, the non-emergency unit shall immediately call for an ALS emergency ambulance, if available, and transfer care for transport to the closest emergency department.

Responsibilities of Dispatch:

1. SO Dispatch shall alert/notify all other 911 dispatch centers (CHP and adjacent jurisdictions), and County OES Mutual Aid Coordinators (fire, law, Medical/Health Operational Area Coordinator (MHOAC)) of the declaration of an MCI.

2. SO Dispatch shall assist, collaborate, and help to coordinate the filling of resource requests from the base station, IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as available. This may include mutual aid resources from outside the operational area, including ground and/or air transportation resources and personnel.

Responsibilities of the Base Station:

1. Upon field notification of an MCI, the base station shall immediately notify area hospitals. If there is the potential for multiple patient destinations, the base station will poll area hospitals for bed availability.

2. The base station shall assist, collaborate, and help to coordinate the filling of all resource requests from the IC, the Medical Group Supervisor, and/or the OES Mutual Aid Coordinators (fire, law, MHOAC), as requested. This may include mutual aid medical resources from outside the operational area.

3. The base station shall coordinate with Dispatch, the IC, the Medical Group Supervisor or designee, and the OES Mutual Aid Coordinators, the deployment of all air resources for the MCI, as requested.

4. The base station shall notify ICEMA and the MHOAC when three (3) or more ambulances are requested for an incident.

5. If the base station is coordinating patient destinations, it will confirm patient departure from scene with Med Comm, if assigned, by providing the departure time and estimated time of arrival (ETA) to the receiving hospital.

6. The base station will advise receiving hospitals of the number/categories of patients en route via approved method (e.g. radio, telephone).

7. If the base station needs additional resources, it shall contact the MHOAC.

Responsibilities of the Receiving Hospital:

1. All hospitals shall respond immediately to any request from the Medical Group Supervisor or designee for bed availability.

2. A receiving facility may not change the destination of a patient.

3. If the receiving facility needs additional resources, it shall contact the MHOAC.

4. Each hospital that received patients from the MCI shall participate in after action reports and improvement plans as necessary.

Responsibilities of the OES Mutual Aid Coordinators (Fire, Law, MHOAC):

1. The Medical Health Operational Area Coordinator (MHOAC) Program is comprised of the personnel, facilities, and supporting entities that fulfill the functions of the MHOAC role as directed by the MHOAC. The MHOAC is a functional designation within the Operational Area, filled by the Health Officer and the local emergency medical services agency administrator (or designee/s), that shall assist the other Operational Area Coordinators (fire, law) in the coordination of situational information and medical and health mutual aid during emergencies.

2. The MHOAC Program is the principal point-of-contact within the Operational Area for information related to the public health and medical impact of an emergency. Within two (2) hours of incident recognition, it is expected that the MHOAC Program will prepare and submit the electronic Health and Medical Situation Report to the activated local emergency management agency (Duty Officer, IC/UC, EOC), to the RDMHC/S Program (REOC), to CDPH, and to EMSA (Duty Officers or EOC if activated).

3. The Mutual Aid Coordinators (fire, law, MHOAC) are responsible for coordinating the process of requesting, obtaining, staging, tracking, using, and demobilizing mutual aid resources. If Unified Command has been established for an incident, health and medical entities request resources through the Operations and Logistics Section of field-level Unified Command, which coordinates the resource fulfillment within the Operational Area, or from neighboring Operational Areas where there are cooperative assistance agreements or day-to-day relationships in existence.

4. If the resource cannot be obtained locally, the MHOAC Program will request health and medical resources from outside of the Operational Area by working with the RDMHC/S Program in preparing and submitting a Health and Medical Resource Request Form to the activated local emergency management agency (Duty Officer, IC/UC, and EOC) and to the RDMHC/S Program (REOC). Examples include, but are not limited to, additional transportation resources (ambulance strike teams, EMS aircraft), accepting specialty facility beds/physicians (multi-trauma, burns, pediatrics), and ventilators.

Medical Control:

1. EMS personnel shall operate within ICEMA “prior to contact” protocols for both medical and trauma patients.

2. When base station consultation occurs, medical control refers to a specific patient and not to the incident as a whole (operational aspects).

3. When multiple hospital destinations exist, medical control has the option of referring the resource establishing radio contact to the base station for bed availability.

Field Documentation:

1. The Medical Group Supervisor (or Med Comm, if established) maintains responsibility to ensure the following:

    a. Utilization of the approved ICEMA/MCI patient care report. This form will include:

        1. Name and location of the incident.

        2. Triage tag number for each patient and the hospital destination.

        3. Brief description of the incident.

    b. Completion of an individual patient care report for each deceased individual at the incident.

    c. Completion of an individual patient care report for all patients with a chief complaint and who “refuse treatment”. As feasible, ask patients to sign a release of liability (e.g. Against Medical Advice (AMA) liability form).

2. Each transporting unit is responsible for generating a patient care report for each patient transported excluding patients transported by non-emergency vehicles. Those transported in non-emergency vehicles will be identified by triage tags. This should include patient tracking tag/number and will indicate the incident name and location.

ADDENDUM

Firescope Operations Procedures of a Multi-Casualty Incident

Operational System Description

The Multi-Casualty Organizational Module within the Firescope Field Operations Guide (ICS 420-1) is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor who reports in most cases to the IC, or the Multi-Casualty Branch Director, if activated. Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The Medical Branch structure in the ICS system is designed to provide the IC with a basic, expandable modular system for managing the incident. The system is designed to be set up consistent in all incidents involving mass casualties and has the ability to expand the incident organization as needed.

Initial Response Organization: Initial response resources are managed by the IC, who will handle all Command and General Staff responsibilities. The resources will respond based on the **operational procedures** (as outlined in this protocol).

Reinforced Response Organization: In addition to the initial response, the Medical Group Supervisor may establish a Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, Medical Communications Coordinator (Med Comm), and Ambulance Coordinator. Also patient treatment areas are established, if needed.

Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch may be designated to provide coordination between the Ambulance Coordinator and the Air Operations Branch. The Extrication Group is established to free entrapped victims.

Multi-Branch Incident Organization: The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one (1) point to avoid overloading hospitals. If necessary for span of control, the IC may appoint a Medical Branch Director to oversee the Medical Group and other relevant groups.

Operational Principles

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, and name the incident. This resource will remain in command until relieved by the public safety agency having jurisdictional authority.

2. The IC will assign the first available resource to triage. Victims shall be triaged according to START/JumpSTART criteria, and ICS shall be implemented according to Firescope and NIMS.

3. The IC will assign the resource with the appropriate communications capability to establish communications with the base station for resource requests, as needed.

4. Treatment areas are set up based upon needs and available resources according to classification of patients (Immediate, Delayed and Minor.) The Treatment Unit Leader will notify Patient Transportation Unit Leader when a patient is ready for transportation and of any special needs (e.g. burns, pediatrics, decontamination). If these positions are not assigned, the Medical Group Supervisor will retain this responsibility.

5. Patients are transported to the appropriate facility based upon patient condition, bed availability, and transport resources. The Medical Group Supervisor is responsible for patient transportation and destination and may assign/delegate this responsibility to a Patient Transportation Unit Leader and a Medical Communications Coordinator who would work together to transport the patients using the appropriate methods to the most appropriate destinations.

6. The Patient Transportation Unit Leader and Med Comm, if assigned, will determine all patient destinations in coordination with the base station.

7. The IC will designate a staging area(s). Transportation personnel should stay with their vehicles to facilitate rapid transport, unless reassigned by the IC or designee.

8. The Patient Transportation Unit Leader will then call for an ambulance or other designated transportation vehicle to respond to the loading area.

9. The Patient Transportation Unit Leader, in coordination with the IC, may put in a request through Dispatch for buses to transport minor or uninjured patients.

10. The Patient Transportation Unit Leader will copy the information from the triage tag onto a Patient Transportation Log, and confirm destination with the ambulance crew, bus, or other driver.

11. The Patient Transportation Unit Leader will notify the Med Comm, if assigned, of patient departure.

12. The transporting unit should contact the receiving facility en route with a patient report, using the incident name to identify the patient.

MCI DEFINITIONS/KEY ICS POSITIONS

MCI DEFINITIONS

NOTE: The ICS Components and Position Definitions are from Firescope Field Operations Guide (FOG).

County Communication Center (CCC): The communications center communicates with all hospitals and the on scene Medical Communications Coordinator/Incident Commander. It obtains hospital bed availability through Reddinet and relay that information back to the Medical Communications Coordinator on scene.

Decontamination (Decon): The physical and/or chemical process of removing or reducing contamination from personnel or equipment, or in some other way preventing the spread of contamination by persons and equipment.

Hazardous Material: Any solid, liquid, gas, or mixture thereof that can potentially cause harm to the human body through respiration, inhalation, ingestion, skin absorption or contact and may pose a substantial threat to life, the environment, or to property.

Incident Command Post (ICP): Location at which the primary command functions are executed and usually coordinated with the incident base.

Incident Command System (ICS): A management system utilized, to rapidly and efficiently manage the scene of any type of an incident. This includes a combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to an incident.

ICS COMPONENTS (FIVE MAJOR MANAGEMENT FUNCTIONS)

Incident Command: Sets the incident objectives, strategies, and priorities and has overall responsibility at the incident or event.

Operations Section: Conducts tactical operations to carry out the plan. Develops tactical objectives and organization, and directs all tactical resources.

Planning Section: Prepares and documents the Incident Action Plan to accomplish the objectives, collects and evaluates information, maintains resource status and maintains documentation for incident records.

Logistics Section: Provides support, resources and all other services needed to meet the operational objectives.

Finance/Administration Section: Monitors costs related to the incident and provides accounting, procurement, time recording, and cost analysis.

Jump START: A pediatric MCI field triage tool developed to parallel the START triage system, which adequately addresses the unique anatomy and physiology of children.

Jump START Pediatric MCI Triage: An acronym for simple triage and rapid transport of patients UNDER THE AGE OF NINE (9). Initial assessment includes ambulatory status (under one year or non-ambulatory), and the following four steps:

Evaluate: Breathing, respiratory rate, palpable pulse and AVPU (*Alert, Voice, Pain and Unresponsive*)

Deceased: Not breathing and no palpable pulse; apneic after five (5) rescue breaths.

Immediate: No spontaneous respirations but breathing spontaneously after airway opened or after five (5) rescue breaths.

- Respiratory Rate <15 or >45
- No palpable pulse
- AVPU "P" (Responds to Pain), or "U" (Unresponsive).

Delayed: No AVPU "A" (Alert), or "V" (Responds to Verbal Stimulus).

Minor: Patient is alert and ambulatory on scene.

Medical and Health Operational Area Coordinator (MHOAC): Responsible for all medical and health operations for the operational area. The EMS Agency Administrator or the County Health Officer is the designated MHOAC and is contacted through the County Communications Center (CCC).

MED-NET: VHF (MED NET) radio approved for Inyo & Mono Counties only.

Multiple Casualty Incident (MCI): The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

National Incident Management System (NIMS): A comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. The intent of NIMS is to be applicable across a full spectrum of potential incidents and hazard scenarios, regardless of size or complexity. The management system

serves to improve coordination and cooperation between public and private entities in a variety of domestic incident management activities.

Rapid Emergency Digital Data Information Network (ReddiNet): An emergency medical communications network linking hospitals, regional EMS agencies, paramedics, dispatch centers, law enforcement, public health officials and other healthcare systems. The system provides participants with tools for managing MCIs, determining hospital bed availability, assessing available healthcare system resources, communicating, participating in syndromic surveillance and sending the network messages.

Simple Triage and Rapid Transport (START): A triage system that provides guidelines for prehospital care personnel to rapidly classify victims so that patient treatment and transport are not delayed. Patients are triaged into the following categories:

Deceased: Patients that do not have spontaneous respirations after repositioning the airway.

Immediate: Patients that exhibit severe respiratory, circulatory or neurological symptoms. Patients that require rapid assessment and medical intervention for survival.

Delayed: Patients that are neither immediate nor minor but will require a gurney upon arrival at the hospital. Delayed patients are the second priority in patient treatment. These patients require aid, but injuries are less severe.

Minor: Patients that are ambulatory, with injuries requiring simple rudimentary first-aid.

Standardized Emergency Management System (SEMS): A system required by Government Code 806 (a), for managing responses to multi-agency and multi-jurisdictional emergencies in California. SEMS consists of five organizational levels which are activated as necessary: (1) field response; (2) local government; (3) operational area; (4) regional; and (5) state.

Staging Area: The location where incident personnel and equipment are assigned on a three minute available status.

Triage: A system that provides guidelines for pre-hospital care personnel to rapidly classify victims so that patient treatment and transport are not delayed

Triage Tag: A tag used by triage personnel to identify and document the patient's triage category.

Unified Command: A team effort that allows all agencies with jurisdictional responsibility for the incident, either geographical or functional, to manage an incident by

establishing a common set of incident objectives and strategies. This is accomplished without losing or abdicating agency authority, responsibility, or accountability.

KEY INCIDENT COMMAND SYSTEM POSTITIONS

Air Ambulance Coordinator: Located on the ground, reports to the Patient Transportation Unit Leader. Essential functions include maintaining communications with the Air Operations Branch Director regarding air ambulance transportation assignments. The Air Ambulance Coordinator is to establish and maintain communications with the Medical Communications Coordinator, the Treatment Dispatch Manager and to provide air ambulances upon request from the Medical Communications Coordinator. T he position is responsible to assure that necessary equipment is available in the air ambulance for patient needs during transportation. The Coordinator is responsible to maintain records as required and Unit/Activity Log (ICS Form 214).

Air Operations Branch Coordinator: Is ground based and is primarily responsible for preparing the air operations portion of the Incident Action Plan and providing logistical support to helicopters operating on the incident.

Delayed Treatment Area Manager: Responsible for the treatment and re-triage of patients assigned to the Delayed Treatment Area and requesting Medical Teams as necessary. This position assigns treatment personnel to patients received in the Delayed Treatment Area, ensures treatment of patients triaged to the Delayed Treatment Area, ensures that patients are prioritized for transportation and coordinates transportation of patients with Treatment Dispatch Manager.

Ground Ambulance Coordinator: Reports to the Patient Transportation Unit Leader with responsibility to manage the ambulance staging area(s) and to dispatch additional ambulances/transportation resources as needed. Essential duties include establishment of appropriate staging area for ambulances; identify routes of travel for ambulances; and maintain communications with the Air Operations Branch Director regarding air ambulance transportation assignments. The position is to maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager and to provide ambulances upon request. The Ground Ambulance Coordinator is to assure that necessary equipment is available in the ambulance for patient needs during transportation, provide an inventory of medical supplies available at ambulance staging area for use at the scene and maintain records as required and Unit/Activity Log (ICS Form 214).

Immediate Treatment Area Manager: Responsible for treatment and re-triage of patients assigned to the Immediate Treatment Area. This position requests medical teams as necessary, assigns treatment personnel to patients, assures that patients are prioritized for transportation and coordinates transportation of patients with the Treatment Dispatch Manager. This position is responsible for identifying immediate patients who exhibit severe respiratory, circulatory or neurological symptoms and who meet one or more categories of Trauma Center Criteria. These patients require rapid assessment, medical

intervention and transport to a 9-1-1 receiving, Trauma Center or other specialty center whenever system resources allow.

Litter Bearer: Personnel assigned by the Triage Unit Leader who are responsible for the transport of patients to the appropriate treatment areas.

Litter Bearer Manager: Position assigned by Triage Unit Leader, the Litter Bearer Manager is responsible for the management of personnel assigned to transport triaged patients to the appropriate treatment areas.

Medical Communications Coordinator (Med Com): Establishes communications with the Communications Center or designated base hospital to obtain status of available hospital beds. The Med Com assigns appropriate patient destinations based on available resources. This position receives basic patient information and condition from Treatment Dispatch Manager and provides the Comm Center or base hospital with information on the assigned patient destinations and transporting ambulance unit.

Medical Group/Division Supervisor: Supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader and Medical Supply Coordinator and establishes command and control within a medical group. This position determines the amount and types of additional medical resources and supplies needed to handle the incident (medical caches, backboards, litters and cots), ensures activation or notification of hospital alert system, local EMS/health agencies and maintains Unit/Activity Log.

Minor Treatment Area Manager: Responsible for the treatment and re-triage of patients assigned to the Minor Treatment Area and requests medical teams as necessary. This position assigns treatment personnel to patients received in the Minor Treatment Area, ensures treatment of patients triaged to the Minor Treatment Area, ensures that patients are prioritized for transportation and coordinates transportation of patients with Treatment Dispatch Manager.

Patient Transportation Group Supervisor: Supervises the Medical Communications Coordinator and the Ground Ambulance Coordinator. The Patient Transportation Group Supervisor is responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition and destination. This position designates the Ambulance Staging Area(s), ensures that patient information and destination are recorded, notifies Ambulance Ground Coordinator of ambulance requests and coordinates requests for air ambulance transportation through the Air Operations Branch Director.

Triage Personnel: Reports to the Triage Unit Leader, triage patients, tag patients and assign them to appropriate treatment areas. Triage personnel direct the movement of patients to proper treatment areas and provide appropriate medical treatment to patients prior to movement as incident conditions allow.

Triage Unit Leader: Supervises Triage Personnel, Litter Bearers, Litter Bearer Manager and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. This position implements the triage process, coordinates movement of patients from the triage area to the appropriate treatment area and maintains security and control of the triage area.

Treatment Dispatch Manager: Responsible for coordinating with the Patient Transportation Unit Leader (or Group Supervisor if established) the transportation of patients out of the Treatment Areas. This position establishes communications with the Immediate, Delayed, Minor Treatment Area Managers and the Patient Transportation Unit Leader. The position verifies that patients are prioritized for transportation and advises Medical Communications Coordinator of patient readiness and priority for transport. This position coordinates transportation of patients with Medical Communications Coordinator and coordinates ambulance loading with the Treatment Managers and ambulance personnel.

Treatment Unit Leader: Assumes responsibility for treatment, preparation for patient transport and directs movement of patients to loading location(s). This position establishes communications and coordination with Patient Transportation Unit Leader and ensures continual triage of patients throughout Treatment Areas. This position directs movement of patients to ambulance loading area(s) and gives periodic status reports to Medical Group Supervisor.

MEDICAL RESPONSE TO HAZARDOUS MATERIALS/TERRORISM INCIDENT

PURPOSE

To supplement the Operational Area Plan Hazardous Material Response Policy. To provide a more detailed medical perspective and serve as a guide to dispatch centers, EMS response agencies, (both public and private) and acute care hospitals and to outline a plan of coordinated medical response to victims of hazardous materials incidents and suspected or actual acts of terrorism for decontamination, protective measures and treatment.

DEFINITIONS

"Exclusion Zone" or "Hot Zone": That area immediately around the spill where contamination does or could occur. It is the innermost of the three zones of a hazardous materials site. It is the zone where mitigation measures take place. Special protection is required for all personnel operating in this zone. All personnel exiting this zone will require decontamination.

"Contamination Reduction Zone" or "Wa**rm Zone"**: That area between the Exclusion Zone and the Support Zone. This zone contains the Contamination Reduction Corridor where the decontamination team decontaminates the personnel leaving the Exclusion Zone. This zone may require a lesser degree of protective equipment than the Exclusion Zone. This area separates the contaminated area from the clean area and acts as a buffer to reduce contamination of the clean area. No contamination should pass through to the clean area.

"Support Zone" or "Cold Zone": The clean area outside of the Contamination Control Line. Special protective clothing is not required. This is the area where resources are assembled to support the hazardous materials operation.

PROCEDURE

Operational Principles for First Responders

1. There is a direct relationship between the type and amount of material and the resultant illness. Exposure may lead to injury and death. Risk to personnel is directly related to the type of contaminant and length of exposure.

2. A single small release, with any degree of personal carelessness, could disable an entire emergency medical system.

3. On scene personnel safety takes priority over any immediate rescue/resuscitation concerns.

4. Prehospital healthcare providers will be unable to respond to other emergencies until decontamination of involved equipment and personnel is accomplished.

Response and Activation

1. Immediate notification to the County Interagency Hazardous Materials Emergency Response Team through appropriate dispatch center. Suspected terrorist activity should also be reported to the appropriate public safety agency having primary investigative authority.

2. Information (if known) to be provided to responding agencies:

    a. Name of substance (this could include basic information such as container information, placards, color/size/odor descriptions and should be obtained from a safe distance); do not make an effort to smell any chemical. If you smell the chemical you have been exposed.

    b. Physical state of material (liquid, gas, solid, powder, etc.).

    c. What is the product doing, i.e., melting, bubbling, off-gassing, still leaking.

    d. Extent of contamination.

    e. Lay of the land.

    f. Wind direction, other weather conditions.

    g. Staging area (up-wind, upstream, uphill).

    h. Alternate travel route.

    i. Consider activation of Multi-Casualty Incident (MCI) if appropriate.

Hospital Notification

1. Hospitals should immediately be made aware of any hazardous materials/terrorism incident through the ReddiNet System or by phone. This early alert will allow the hospital(s) to prepare for the eventuality of receiving patients from the incident.

2. This notification should be made even if it appears no victims have received exposure or contamination. In some cases, individuals may arrive at local hospitals without going through decontamination. These victims have the potential for exposure risk and contamination of personnel and facilities and would result in the lengthy shutdown of a facility while specialized decontamination teams render the facility safe.

3. Consider requesting additional hazmat and/or decon equipment from local Fire jurisdiction to assist with larger numbers of walk-ins.

First Responding Ambulance

1. If an ambulance is the first responder, upon suspicion of a hazardous material release, the crew should:

   a. Advise the appropriate dispatch center of the situation. This information will minimize unnecessary and inadvertent exposure to other public safety personnel and equipment.

   b. The ambulance crew shall await arrival of appropriate resources prior to rendering any treatment.

2. Medical responders will always work in the Support Zone. They should never enter the Exclusion or Contamination Reduction Zones.

3. The Incident Commander (IC) will determine the level of personal protective equipment (PPE) needed in each zone.

4. Only personnel who are wearing proper PPE shall make contact with victims in the Exclusion or Contamination Reduction Zones.

5. The IC or designee will make all decisions regarding the mode of transportation for injured persons.

On Site Treatment

1. <u>Within the Exclusion and Contamination Reduction Zones</u>

   Self-contamination potential and restrictions caused by PPE make definitive treatment within these zones difficult. Only those public safety responders trained in providing medical care in a hazardous environment, and limited to basic life support (BLS) procedures should provide medical treatment within these zones. This treatment should be followed by rapid transportation to the Containment Reduction Zone/Decon. Any ambulatory victims need to be directed to an Ambulatory Decon Area/Line for decontamination. It is possible some of these people can decontaminate themselves.

2. <u>The Safe Zone</u>

   Paramedic medical interventions should begin only after the decontamination process. Treatment should be in accordance with prevailing medical standards of care and by consultation with the Base Station, if indicated. One hospital should act as the coordinating hospital using resources such as Regional Poison Control Center and/or Toxic Information Center.

Medical Transportation

1. Ground Ambulance Preparation

   a. If a victim is contaminated, there will be no ambulance transport until gross decontamination is performed.

   b. If transport is deemed necessary by the IC or designee then:

      i. A plastic sheet should be placed on the ambulance floor prior to transport.

      ii. Adequate ventilation should be provided to avoid accumulation of toxic chemical levels in the ambulance.

2 Helicopter Consideration

   a. A decision to utilize helicopter services should be decided by the collaboration of the IC, or designee, and the flight crew.

   b. Guidelines outlined in Item 1b. above should be applied to preparing a helicopter prior to transporting patients.

   c. Air transport of patients should be considered as a last resort.

Determination of Destination Hospital and Related Preparation

1. Destination Hospital

   The destination hospital should be determined by the standard of the closest and most appropriate. When information indicates the hazardous material possesses a significant threat to hospital personnel, consideration should be given in consultation with the Base Station physician to triage the patients to a single hospital. This decision should be made based on the potential danger to attending staff, threatened facility closure and the ability of the hospital to handle such cases.

   2. Preparation by Receiving Hospital(s)

      a. Internal preparation according to hospital policies and procedures.

      b. Anticipate walk-in contaminated patients.

      c. Anticipate the need for fine detail decontamination (e.g., fingernail beds and ear canals of persons who were field decontaminated). Check for contact lenses.

      d. In the event contaminated victims arrive at the hospital, the hospital should be prepared to decontaminate victims in a pre-designated area

outside of the Emergency Department. Some accessories may include:

i. Temperature controlled water hose (low pressure).

ii. Acceptable catch basin.

iii. Expendable or easily decontaminated gurney.

iv. Towels and sheets for patient.

v. Movable screens for privacy.

vi. Plastic lined garbage receptacles for contaminated clothes and equipment. Personal effects of victims involved in a terrorist event should be bagged and labeled as possible evidence for collection by law enforcement.

vii. Consider requesting assistance from local hazmat teams for additional assistance.

viii. A current contract with a State licensed hazardous materials contractor to dispose of contaminated materials and properly perform area decontamination should already be in place.

Base Station Medical Control Roles and Responsibilities

1. Assignment of a Mobile Intensive Care Nurse (MICN)/Emergency Department physician or designee to the ReddiNet System, if available, throughout the duration of the incident.

2. Collaboration of Base Station physician and the IC/Technical Reference Team Leader as to the best method of decontamination.

3. Provide to paramedics, online information regarding prodromal symptoms that may be expected as a result of exposure to hazardous materials or weapons of mass destruction (WMD) agents.

4. Anticipate walk-in contaminated patients and initiate appropriate action.

5. Assist in consultation and determination of destination.

Decontamination of Prehospital Equipment and Personnel

Proper protection of equipment and supplies should minimize equipment and personnel out of service due to any contamination that may occur during transport. If the vehicle and equipment are contaminated during transport, they should not return to service until adequately decontaminated by qualified personnel. In addition, the following procedure should be followed:

1. Personal protective garments should be discarded in designated receptacles at hospital facilities as soon as practical.

2. Decontamination should take place under the direction of designated hazardous materials personnel.

3. Decontamination should take place in an area where wastewater can be contained.

4. No medical vehicle, associated hardware, or supplies shall be released for service until clearance is received from designated hazardous materials personnel.

ICEMA GROUND BASED AMBULANCE RATE SETTING POLICY - SAN BERNARDINO COUNTY

PURPOSE

To establish the maximum charges that San Bernardino County ground ambulance providers may charge for the care and transport of patients and outline the mechanism for calculating annual ground ambulance rates.

POLICY

No ambulance service shall charge more than the following rates:

1. RATES FOR ONE PATIENT: The schedule of maximum rates that may be charged for ambulance service for one (1) patient shall be reviewed by ICEMA on an annual basis.

2. RATES FOR MULTIPLE PATIENTS:

    a. Each additional stretcher or gurney patient carried at the same time may be charged the full base rate for the response to the call and half the mileage rate.

    b. Each additional sit-up patient shall be charged half the base rate for response to the call and half the mileage rate.

    c. The provider may prorate all mileage charges between all patients transported so that all patients are charged the same fee for mileage.

    d. This section does not apply to contractual agreements.

3. NO CHARGE TRANSPORTS: No charge shall be made for transporting uninjured or well persons who accompany a patient.

4. COMPUTATION OF RATES: All rates are to be computed from the time the ambulance arrives for hire until the ambulance delivers the patient to the appropriate destination, and is discharged by the patient or his representative, attending physician, or emergency receiving facility.

5. FEES FOR SERVICE, SUPPLIES AND EQUIPMENT:

    a. When a ground ambulance has been dispatched and ambulance personnel and/or equipment are directly involved with patient care in situations where

an EMS aircraft transports, then the ambulance service shall be entitled to charge an appropriate fee for its service, supplies and equipment.

b. Under no circumstances shall ambulance personnel dispatched on an emergency 9-1-1 call attempt to collect for the service prior to the delivery of the patient at an appropriate medical facility.

PROCEDURE

1. ANNUAL RATE ADJUSTMENT: At the direction of ICEMA, the ambulance rates established under this section shall apply to all providers of ground based ambulance services.

   a. ICEMA shall be responsible for calculating rate adjustments.

   b. The Consumer Price Index (CPI) adjustment shall be calculated by March 15 of each year. The CPI used shall be compiled and reported by the Bureau of Labor Statistics for the preceding 12-month period (January through December) utilizing the "Annual" column of the adjustment year. The following CPI selections shall be utilized:

      - All Urban Consumers
      - Not Seasonally Adjusted
      - Western Region, Los Angeles, Riverside, Orange Counties, CA
      - Medical Index
      - Transportation Index

      The CPI adjustment shall be effective as of the first day of July of each year.

   c. If selected CPI's are discontinued or revised, another government index or computation which replaces it shall be used in order to obtain substantially the same result.

   d. The current rates shall be adjusted for changes in the CPI as set forth herein. The adjustments shall be made on July 1 of each year based upon the change in the CPI from January 1 of the preceding year to December 31 of the same calendar year.

      The CPI adjustment shall be determined by taking the difference between the annual CPI's *(previous and adjustment years)* then by multiplying the result by zero point zero five (0.05) for the Transportation Index. The same process is applied to the Medical Index multiplying the result by zero point ninety-five (0.95). The two (2) sums are then added together and multiplied by one point five (1.5) to arrive at the total amount of the change in CPI for the annual base rate comparison. Yearly CPI adjustments shall not exceed five percent (5%) or less than zero for any single year.

2. ANNUAL RATE COMPARISON STUDY: The maximum base rates shall be reviewed in accordance with the following procedures, and adjusted annually, if appropriate, on July 1 every year. In conjunction with the rate adjustment and pursuant to Section 31.0820(e), the local EMS agency (ICEMA) shall review the ALS and BLS ground ambulance base rates of counties with similar demographics to determine the ALS and BLS average base rates in effect for these counties as of the review date.

   If the San Bernardino County rates are at the average or greater, no adjustment to the ambulance rates will be made under this provision. If the San Bernardino County rates are less than the average, an appropriate adjustment to the ambulance rates shall be made to bring them towards the average. No ambulance rate comparison adjustment shall be greater than five percent (5%).

3. MILEAGE CHARGE RATE ADJUSTMENT: In addition to, and not in lieu of, annual CPI adjustments may be made, in an amount equal to the ambulance providers' extraordinary increase or decrease in fuel costs using the following CPI selections:

   - Average Price Data
   - A421 Los Angeles-Riverside-Orange County, CA
   - Table, 7471A
   - Gasoline, all types, per gallon/3.785 liters

   This value will be reduced by the corresponding sub-value in the CPI transportation index used above in the annual comparison.

4. EXTRAORDINARY RATE ADJUSTMENTS:

   a. Extraordinary costs increases or decreases shall be subject to ICEMA Governing Board approval.

   b. Requests must be made in writing and use most recent specific CPI and include the previous calendar year plus the sum of the most recent CPI for the current year, divided by the number of total months, for an average.

   c. Extraordinary cost rate increase requests may be requested quarterly and will be reviewed within thirty (30) days of receipt. Any approved implementation will become effective upon the beginning of the next calendar quarter and will not be retroactive.

   d. The ambulance provider must demonstrate actual and substantial financial hardship as a result of factors beyond its reasonable control and provide records deemed necessary to verify such hardship. This procedure may also be used to obtain rate adjustments due to changes in the CPI that are greater than the five percent (5%) cap under the yearly CPI adjustment, above.

e. ICEMA, at the time of any extraordinary adjustment under subsection (1), above, shall request an audit of books and records of an ambulance service provider for the purpose of verifying revenue and cost data specifically associated with the extraordinary rate increase request. Audits shall be carried out by a person selected and approved by ICEMA. If ICEMA and ambulance service provider cannot agree on a person to perform the audit, then the audit shall be carried out by a Certified Public Accountant selected by the ICEMA Executive Director.

Any charge, cost or fee, shall be paid by the ambulance service provider. ICEMA may deny any adjustment if an audit is requested and not produced. Every audit shall be done promptly and within thirty (30) days of submission.

PARAMEDIC VACCINATION POLICY

POLICY STATEMENT

The decision to activate this policy will be incident dependent, time limited and based on guidance from the ICEMA Medical Director and/or designee, and in collaboration with the local Health Officer as deemed necessary or essential for successful vaccination programs in emergency situations.

AUTHORITY

Under a declared Public Health Emergency by the local Public Health Officers within the ICEMA region (Inyo, Mono and San Bernardino Counties), California Health and Safety Code, Section 101080.

PURPOSE

To develop a program that utilizes ICEMA accredited paramedics (EMT-Ps) during an H1N1 Public Health Emergency to administer H1N1 and/or seasonal flu vaccine injections.

OBJECTIVE

Train EMT-Ps to administer H1N1 and/or seasonal flu vaccinations to qualified EMS healthcare workers quickly and efficiently. Qualified EMS healthcare workers are defined as those EMS personnel who have direct patient care responsibilities.

TRAINING

1. H1N1 flu prophylaxis and vaccination training for the EMT-P will be provided by EMS provider agencies and consist of a self-directed review of EZIZ or EMSA developed training modules that cover:

    - Infectious Diseases and Influenza
    - Principles of Vaccinations
    - Medication Profile - Vaccinations
    - Review of Anaphylaxis
    - Required Documentation
    - Related Policies, Protocols and Procedures
    - Role of EMS in a Public Health Emergency Vaccination Program
    - Vaccine Handling and Storage

2. All records will be maintained by the continuing education (CE) provider for four (4) years, and shall include:

   a. Complete outlines for the course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.

   b. Record of time, place and date each course is given and the number of CE hours granted.

   c. An ICEMA approved roster signed by course participants to include name and license number of the individuals.

3. After completing the training and successfully passing a written exam, the EMT-P will be certified to administer H1N1 prophylaxis flu medications and/or seasonal flu vaccinations within the ICEMA region. EMT-Ps will not be allowed to administer the vaccine until rosters are sent to ICEMA. The rosters may be faxed or e-mailed to ICEMA.

QUALITY IMPROVEMENT

ICEMA, Public Health or EMS provider agency's supervisory staff will monitor EMT-Ps to ensure that individuals receiving medications/vaccinations are being assessed for any adverse effects or allergic reactions at each vaccination location.

Proper use of personal protective equipment (PPE) by the vaccinators will be monitored by the supervisors at each vaccination location.

AED SERVICE PROVIDER - PUBLIC SAFETY

I. PURPOSE

To establish a standard mechanism for approval of Public Safety automatic external defibrillator (AED) service providers in the ICEMA region.

II. DEFINITIONS

Firefighter: Any regularly employed and paid officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.

Lifeguard: Any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.

Peace Officer: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department.

Public Safety AED Service Provider: An agency or organization which is responsible for and is approved to operate an AED.

Public Safety Personnel: Any firefighter, peace officer, or lifeguard.

II. POLICY

Public Safety AED service providers shall be approved by ICEMA prior to beginning service. In accordance with California Code of Regulations, Title 22, Division 9, Chapter 1.5, approval may be revoked or suspended for failure to comply.

III. PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

Submit a Specialty and Optional Scope Program Approval Application, which is found on the ICEMA website at ICEMA.net (approval is required every two (2) years), with the following information to ICEMA for review and approval:

- Description of the geographic area served by the provider.

- The model name of the AED(s) to be utilized.
- Name of individual responsible for managing the AED program.
- Identify the primary instructor with qualifications.
- Identify the training program to be used.
- Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
- Procedures for maintenance of the AED.
- Policies and procedures to collect, maintain and evaluate patient care records.
- Identify the Medical Director responsible for the provider's AED program.

IV. RECORD KEEPING AND REPORTING REQUIREMENTS

- An AED Use Notification form, which is found on the ICEMA website at ICEMA.net, must be provided to the Public Safety AED service provider's Medical Director who is responsible for the provider's AED program within 24 hours of use.
- The following data shall be collected and reported to ICEMA annually by March 1st for the previous calendar year. An AED Annual Usage Report form is available on the ICEMA website at ICEMA.net.
    - The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known.
    - The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest.
    - The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.

AED SERVICE PROVIDER - LAY RESCUER

I. PURPOSE

To assist businesses and organizations implement Lay Rescuer automated external defibrillator (AED) service provider programs within the ICEMA region. Using (AEDs) for out-of-hospital cardiac arrests has been proven to increase survival rates. ICEMA supports the use of Lay Rescuer (non-licensed or non-certified personnel person) access AEDs within the ICEMA region, and this policy is intended to facilitate the proliferation of AED programs.

II. REQUIREMENTS OF BUSINESS/ORGANIZATION/INDIVIDUAL

- Become familiar and comply with California Code of Regulation, Title 22, Division 1.8.

- Complete an AED Site Notification form, which is found on the ICEMA website at ICEMA.net, listing each AED unit being deployed in the ICEMA region. Submit the form to:

  ICEMA
  1425 South "D" Street
  San Bernardino, CA 92415-0060

- If any of the information becomes outdated, re-submit an AED Site Notification form (i.e., the AED is moved to a different location, a new AED is purchased, etc.), which is found on the ICEMA website at ICEMA.net.

- Every time an AED is used, complete the AED Use Notification form, which is found on the ICEMA website at ICEMA.net, and submit via fax to ICEMA at (909) 388-5825, within 24 hours of use.

III. IMPLEMENTATION CHECKLIST

Listed below are key elements taken from the California Code of Regulation, Title 22, Division 1.8. Each element must be satisfied to implement Lay Rescuer AED programs within the ICEMA region.

☐	Notify ICEMA of the existence, location, and type of every AED within the ICEMA region. The business or organization responsible for the device must, at the time the device is acquired and placed, notify ICEMA. Complete an AED Site Notification form.
☐	Expected AED users/rescuers must complete a training course in cardiopulmonary resuscitation (CPR) and in use of the AED device. The training curriculum must comply with regulations adopted by the California Emergency Medical Services Authority, the standards of the American Heart Association, or the American Red Cross. The training shall include a written and skills examination.
☐	Any AED training course for non-licensed or non-certified personnel (Lay Rescuers) shall have a physician medical director.
☐	A California licensed physician and/or surgeon must be involved in developing an internal emergency response plan for the site of the AED. The physician/surgeon is responsible for ensuring the businesses or organization's AED program complies with State regulations and requirements for training, notification, and maintenance. The internal emergency response plan shall include, but not be limited to, the provisions for immediate notification of 9-1-1 and AED-trained on-site personnel, upon discovery of the emergency. As well as procedures to be followed in the event of an emergency that may involve the use of an AED.
☐	The business/organization/lay rescuer in possession of the AED must comply with all regulations governing the training, use, and placement of the device.
☐	The AED must be maintained and regularly tested according to the manufacturer's operation and maintenance guidelines, the American Red Cross, and American Heart Association. Maintenance and testing must also comply with any applicable rules and regulations set forth by the US Food and Drug Administration and any other applicable authority.
☐	The AED must be checked for readiness at least once every thirty (30) days and after each use. Records of these periodic checks shall be maintained by the business/organization in possession of the device.
☐	A mechanism shall exist to ensure that any person rendering emergency care or using the AED activate the emergency medical services system (9-1-1) immediately. Further, the business/organization in possession of the AED is responsible for reporting any use of the AED to the physician medical director and to ICEMA. Complete an AED Use Notification form.
☐	A mechanism shall exist that assures the continued competency of the expected AED users/ rescuers employed by the business/organization in possession of the AED. Such mechanism shall include periodic training and skills proficiency demonstrations sufficient to maintain competency.
☐	For every AED unit acquired up to five (5) units, no less than one (1) employee per AED unit shall complete a training course in CPR and AED. After the first five (5) AED units are acquired, for each additional five (5) AED units acquired, one (1) additional employee shall be trained beginning with the first additional AED unit acquired. The business/organization in possession of the AED shall have trained employees available to respond to a cardiac emergency during normal operating hours.

SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL POLICY

I. PURPOSE

To provide guidelines for the application and renewal of advanced life support (ALS) or basic life support (BLS) specialty or optional scope of practice programs.

II. DEFINITIONS

AED Service Provider - Public Service: A specialty program for public safety personnel. (See ICEMA Reference #6040 - AED Service Provider - Public Safety.)

Emergency Medical Dispatch (EMD) Program: The reception, evaluation, processing and provision of dispatch life support; management of requests for emergency medical assistance; ongoing evaluation and improvement of the emergency medical dispatch process. (See ICEMA Reference #6120 - Emergency Medical Dispatch Center Requirements.)

Mobile Medic Specialty Program: A specialty program that utilizes boats, bicycles, motorcycles, golf carts and/or powered all-terrain vehicles or for ALS or BLS response designed to deliver EMT, AEMT, and/or EMT-P to the scene of injury and/or transport a patient from the scene of injury to other awaiting EMS units.

Optional Scope Program: Any EMT program that may require approval from the ICEMA Medical Director to function outside of the basic scope of practice that is not initiated region-wide.

Specialty Program: Any program that may require approval from the ICEMA Medical Director to function due to regulations or any variance from standard ICEMA policies or protocols either in equipment or procedures.

Tactical Medicine Program: A specialty program that meets all the prerequisites established by POST/EMSA for the delivery of emergency medical care during law enforcement special operations. (See ICEMA Reference #6110 - Tactical Medicine Program.)

III. POLICY

- All providers interested in providing ALS specialty or EMT optional scope programs shall submit an application which will undergo a review process to determine eligibility.

- All specialty and optional scope programs must submit a new application and be approved every two (2) years.

IV. PROCEDURE FOR SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL

- Submit an original application indicating the type of program. The Specialty and Optional Scope Program Approval Application is available on the ICEMA website at ICEMA.net.

- Submit a copy of the proposed or renewal program which shall include:

  - A statement demonstrating a need for the program.

  - A description of the geographic area within which the specialty program will be utilized.

  - A detailed description of the operation of the program (i.e. special events, 24/7) and how the program will be implemented.

  - A description of how the program will interface with the EMS system and 9-1-1.

  - A detailed description of the training program. For optional scope programs, include provisions for written test and demonstration of skills competencies.

  - A detailed list of employees participating in this program. If there are changes in employees ICEMA must be notified within 10 days.

  - A detailed description of any deviations from the Standard Drug and Equipment List, how equipment and drugs will be stored and/or transported and a program for maintenance of the equipment.

  - A process for the reporting of any deviations or adverse events.

  - A quality improvement plan or an amendment to the EMS providers Quality Improvement Plan that describes the quality improvement process for the specialty program. The plan must comply with all provisions of the ICEMA Quality Management Plan and include provisions for 100% review of all patient care reports in which the specialty or optional scope program was utilized.

- Additional procedures for Mobile Medic Specialty Programs:

  - A statement indicating compliance with Department of Motor Vehicles rules for personal safety equipment and/or vehicle registration.

- A list of type of vehicles utilized (bicycles, motorcycles, ATV).
- Type of patient care report (PCR) utilized and process for transfer of patient care documents in the field.
- Type of communication devices utilized and interface with ALS provider and transport.

- Additional procedures for EMT King Airway Optional Skills Program:
  - Accreditation for EMTs to practice optional skills is limited to those whose certificate is active and are employed within the ICEMA region by an authorized provider.
  - Training in the use of perilaryngeal airway adjuncts to include not less than five (5) hours with skills competency demonstration every 2 years for accredited EMTs in continuing programs.
  - Comply with state regulations for EMT Optional Skills training and demonstration of competency.

V. PROCEDURES FOR SPECIALTY PROGRAMS

- A patient care report is required for all patient contacts by EMS personnel (BLS or ALS) that result in a patient assessment. Patients refusing care or declining further care after treatment must sign a refusal of care and/or Against Medical Advise form.
- If paper forms are utilized, EMS Providers are required to submit an approved Electronic Patient Care Report (ePCR) by the end of shift or within 24 hours of the close of the event (whichever is less).
- Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.
- All patient care reports will be reviewed by the EMS Provider as part of their Continuous Quality Improvement program.

VI. DRUG AND EQUIPMENT LISTS

- Equipment and supplies carried and utilized by specialty program personnel shall be consistent and compatible with the drugs and equipment normally carried by ALS units.
- Equipment and supplies shall be based on the appropriate level of personnel utilized for the particular event.

VII. REFERENCES

Number	Name
6030	AED Service Provider - Public Safety
6110	Tactical Medicine Program
6120	Emergency Medical Dispatch Center Requirements

CARDIOVASCULAR ST ELEVATION MYOCARDIAL INFARCTION RECEIVING CENTERS DESIGNATION POLICY

I. PURPOSE

A Cardiovascular ST Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) will be the preferred destination for patients who access the 9-1-1 system meeting the defined criteria and show evidence of a STEMI on a 12-lead electrocardiogram (ECG). These patients will benefit from rapid interventions via cardiac catheterization interventions.

II. POLICY

The following requirements must be met for a hospital to be designated as a SRC by ICEMA:

- An ICEMA approved receiving hospital which is a full service general acute care hospital.
- Licensure as a Cardiac Catheterization Laboratory (Cath Lab).
- Intra-aortic balloon pump capability.
- Cardiovascular surgical services permit.
- An alert/communication system for notification of incoming STEMI patients, available twenty-four (24) hours per day, seven (7) days per week (i.e., in-house paging system).
- Provide continuing education (CE) opportunities twice per year for emergency medical services (EMS) field personnel in areas of 12-lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

III. STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a SRC:

- <u>Medical Directors</u>

  The hospital shall designate two (2) physicians as co-directors of its SRC program. One (1) physician shall be a board certified interventional cardiologist with active Percutaneous Coronary Intervention (PCI) privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

- Nursing Coordinator

  The hospital shall designate a SRC Nursing Coordinator who is trained or certified in Critical Care nursing.

- On-Call Physician Consultants and Staff

  A daily roster of the following on-call physician consultants and staff that must be promptly available within thirty (30) minutes of notification.

  - Cardiologist with PCI privileges.
  - Cardiovascular Surgeon.
  - Cardiac Catheterization Laboratory Team.
  - Intra-aortic balloon pump nurse or technologist.

- Emergency Department Liaison Nurse

  The non-base hospital shall designate an SRC Emergency Department Liaison Nurse who has a minimum of two (2) years emergency department experience to facilitate communication and education between the Cath Lab, emergency department and EMS field personnel.

IV. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of a STEMI patient is not possible.

Acknowledgement that STEMI patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only) (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues, i.e., bomb threat, earthquake damage, hazardous material or safety and security of the hospital). A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.

- Prompt acceptance of STEMI patients from other SRHs that do not have PCI capability. STEMI diversion is not permitted except for internal disaster. Refer to ICEMA Reference #8120 - Continuation of Care (San Bernardino County Only). However, STEMI base hospitals are allowed to facilitate redirecting of STEMI patients to nearby SRCs when the closest SRC is over capacity to avoid prolonged door to intervention time. SRC

and base hospitals shall ensure physician to physician contact when redirecting patients.

- Cath Lab Team activation policy which requires immediate activation of the team upon EMS notification when there is documented STEMI patient en route to the SRC, based on machine algorithm interpretation.

V. DATA COLLECTION

All required data elements shall be collected and entered in an ICEMA approved STEMI registry on a regular basis and submitted to ICEMA for review.

VI. CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

SRC shall develop an on-going CQI program which monitors all aspect of treatment and management of suspected STEMI patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- Morbidity and mortality related to procedural complications.
- Detail review of cases requiring emergent rescue Coronary Artery Bypass Graph (CABG).
- Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.
- Detailed review of cases requiring redirection of EMS STEMI patients to other SRCs as a result of SRC over capacity and prolonged delay of door-to-intervention time.
- Active participation in each ICEMA STEMI CQI Committee and STEMI regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication.

VII. PERFORMANCE STANDARD

SRCs must achieve and maintain a door-to-balloon (D2B) time of less than or equal to ninety (90) minutes in 75% of primary PCI patients with a STEMI, in accordance with D2B: An Alliance for Quality Guidelines. If this standard is not achieved, the SRC may be required to submit an improvement plan to ICEMA addressing the deficiency with steps being taken to remedy the problems.

VIII. DESIGNATION

- The SRC applicant shall be designated after satisfactory review of written documentation and an initial site survey by ICEMA or its designees and completion of an agreement between the hospital and ICEMA.

- Accreditation by the Society of Cardiovascular Patient Care.

- Initial designation as a SRC shall be in accordance with terms outlined in the agreement.

- Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

IX. REFERENCES

Number	Name
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)
8120	Continuation of Care (San Bernardino County Only)

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

Specialty Program

PURPOSE

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

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

AUTHORITY

California Code of Regulations, Title 22; Division 9, Chapter 4, Section 100145.
California Vehicle Code, Section 23158 (d)

POLICY

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

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

PROCEDURE

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

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

2. The request must be in writing from the peace officer.

3. Blood draw kits will be supplied by the law enforcement agency.

4. The procedure will be performed based on standard practice, pursuant to the directions on the supplied kit (Benzalkonium Chloride) and documented as such. The obtained sample will be the property of the arresting officer.

5. A patient care record must be completed for all requests and include, at a minimum, the following information:

    a. Patient name

    b. Sex

    c. Date and time

    d. Name of requesting peace officer

    e. Brief medical history including medications and allergies.

    f. Vital signs

    g. Brief narrative including the kit number, skin preparation used, and location of the blood draw.

    h. If a second needle stick is required, the site and skin preparation will be documented.

    i. The patient's consent for the procedure and the peace officer's request for the procedure will also be documented with the name and badge number of the peace officer.

6. Base Station contact is not required unless there is a medical necessity.

CONTRAINDICATIONS

1. Patient history of an allergy to the antiseptic used in the kit, or to Betadine. The EMT-P must refuse the request to draw and inform the peace officer of the situation.

2. If the patient is on anti-coagulant therapy, direct pressure will be held on the site for at least one (1) full minute. A pressure dressing will be applied.

3. No blood draws will be performed on patients with hemophilia.

4. No blood draws will be performed on combative persons.

5. If the patient refuses the blood draw for any reason, the EMT-P will document and stop procedure immediately. The EMT-P is not allowed to draw blood on a struggling or restrained patient. The patient must be cooperative.

TRAINING

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

Additional documentation:

1. A log will be kept of all blood draws for DUI by the EMT-P's employer for quality improvement (QI) purposes.

2. The EMT-P should provide his or her name and any other information needed to complete the *Blood Draw Request Form* from the law enforcement agency.

FIRELINE PARAMEDIC

I. PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic (EMT-P) deployed to function as a fireline paramedic (FEMP).

This protocol is for use by authorized FEMPs during fire suppression activities and treatment of fire suppression personnel only.

II. REQUIREMENTS

1. Must be a currently licensed paramedic in California.

2. Must be currently accredited paramedic in the ICEMA region.

3. Must be currently employed by an ICEMA approved ALS provider.

4. The FEMP will follow FIRESCOPE FEMP ICS 223-11 Position Manual and all other ICS protocols.

5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.

6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.

7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.

8. The FEMP may not perform skills outside of the ICEMA scope of practice.

III. PROCEDURE

1. The EMS provider will notify ICEMA of the deployment of the FEMP to an incident. Use the Fireline Paramedic (FEMP) Deployment Notification form, which is on the ICEMA website at ICEMA.net.

2. The FEMP will carry inventory in the advanced life support (ALS) pack as per the below inventory list (see Section IV. Fireline EMT-P (ALS) Pack

Inventory. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.

3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.

4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.

5. FEMP may carry an inventory of controlled substances (i.e., Fentanyl and Midazolam) if authorized by the employing agency's Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.

6. Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base hospital should be established as soon as possible.

7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care records will be reviewed by the provider agency and ICEMA for QI purposes.

8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with basic life support (BLS) treatment and supplies.

IV. FIRELINE EMT-P (ALS) PACK INVENTORY

***Minimum Requirements**: The weight of the pack will dictate if the EMT-P chooses to carry additional ALS supplies.*

MEDICATIONS/SOLUTIONS

Medications/Solutions	ALS
Albuterol Solution 2.5 mg Handheld Nebulizer or Multidose Inhaler	4
Atropine Sulfate 1 mg	2
Ipratropium Bromide Solution 0.5 mg Handheld Nebulizer or Multidose Inhaler	4

Medications/Solutions	ALS
Lidocaine 100 mg IV pre-load	2
Aspirin 80 mg chewable	1 bottle
Dextrose 10%/250 ml (D10W 25 gm) IV/IO Bolus	1
Diphenhydramine 50 mg	4
Epinephrine 1: 10,000 1 mg	2
Epinephrine 1: 1000 1 mg	4
Glucagon 1 mg	1
Nitroglycerin - Spray 0.4 metered dose and/or tablets (tablets to be discarded 90 days after opening)	1 (equivalent of 10 patient doses)
Saline 0.9% IV 1000 ml may be divided in two 500 ml bags or four 250 ml bags.	

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	ALS
Midazolam	20 mg
Fentanyl (amount determined by the medical director)	200 - 400 mcg

ALS AIRWAY EQUIPMENT

Airway Equipment	ALS
Endotracheal Tubes - 6.0, 7.0 and/or 7.5 cuffed with stylet	1 each
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1 each
King Airway - Size 3, 4, and 5	1 each
ET Tube holder	1
End Tidal CO2 Detector	1
Needle Cricothyrotomy Kit	1
Needle Thoracostomy Kit	1

IV/MEDICATION ADMINISTRATION SUPPLIES

IV/Medication Administration Supplies	ALS
IV administration set macro drip	2
Venaguard	2
Alcohol preps	6

IV/Medication Administration Supplies	ALS
Betadine swabs	4
Tourniquet	2
Razor	1
Tape	1
IV catheters - 14, 16, 18 and 20 gauge	2
10cc syringe	2
1 cc TB syringe	2
18 gauge needle	4
25 gauge needle	2

MISCELLANEOUS EQUIPMENT

Miscellaneous	ALS
Sharps container	1
Narcotic storage per protocol	
FEMP pack inventory sheet	1
Patient care record or ePCR (Toughbook)	
AMA forms	3

Equipment	ALS
Compact AED or compact monitor defibrillator combination	
Appropriate cardiac pads	
Pulse oximetry (optional)	
Glucometer, test strips and lancets	4

The BLS pack and supplies will be carried by the FEMT or accompanying FEMP. Personal items and supplies cannot be carried in either the ALS pack or the BLS pack.

NEUROVASCULAR STROKE RECEIVING CENTERS DESIGNATION POLICY

(San Bernardino County Only)

I. PURPOSE

To provide developing guidelines to rapidly transport stroke patients who access the 9-1-1 system to a designated Neurovascular Stroke Receiving Center (NSRC) when indicated. Patients transported to NSRC will benefit from rapid assessment, intervention and treatment at a dedicated stroke specialty center. Patients will meet the defined criteria for triage as an acute ischemic or hemorrhagic cerebral vascular event.

II. POLICY

The following requirements must be met for a hospital to be an ICEMA designated NSRC:

- An ICEMA approved receiving hospital which is a full service general acute care hospital.
- Accreditation as a Primary Stroke Center by TJC or HFAP and proof of re-accreditation every two (2) years.
- An alert/communication system for notification of incoming stroke patients, available twenty-four (24) hours per day, seven (7) days per week (i.e., in-house paging system).
- Provide continuing education (CE) opportunities twice per year for NSRC, NSRH and emergency medical services (EMS) field personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.
- Lead public stroke education efforts at the appropriate educational level and report annually to ICEMA.

III. STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a NSRC:

- <u>Medical Directors</u>

  The hospital shall designate two (2) physicians with hospital privileges as co-directors of its NSRC program. One (1) physician shall be board certified or board eligible by the American Board of Medical Specialties or American

Osteopathic Association, neurology or neurosurgery board. The co-director shall be a board certified or board eligible emergency medicine physician.

- Nursing Coordinator

  The hospital shall designate a NSRC Nursing Coordinator who has experience in critical care or emergency nursing, and has advanced education in stroke physiology or at least has two (2) years dedicated stroke patient management experience. Certification in critical care or emergency nursing is preferred.

- On-Call Physicians Specialists/Consultants

  A daily roster of the following on-call physician consultants and staff must be promptly available within thirty (30) minutes of notification of "Stroke Alert" twenty-four (24) hours per day, seven (7) days per week.

  - Radiologist experienced in neuroradiologic interpretations.
  - On-call Neurologist and /or tele-neurology services available twenty-four (24) hours per day; seven (7) days per week.
  - If neurosurgical services are not available in-house, the hospital must have a rapid transfer agreement in place with a hospital that provides this service. The agreement must be on file with the ICEMA. NSRCs must promptly accept rapid transfer requests from NSRCs. Additionally, the hospital must have a rapid transport agreement in place with an ICEMA permitted transport provider for that exclusive operation area (EOA).

IV. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- Stroke Team alert response policy upon EMS notification of a "Stroke Alert".
- Rapid assessment of stroke patient by Emergency and Neurology Teams.
- Prioritization of ancillary services including laboratory and pharmacy with notification of "Stroke Alert".
- Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for "Stroke Alert" patients.

- Acknowledgement that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues, i.e., bomb threat, earthquake damage, hazardous material or safety and security of the hospital.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.

- Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care Teams.

- Readiness of diagnostic computed tomography (CT) and magnetic resonance imaging (MRI), upon notification of Stroke Team.

V. DATA COLLECTION

Data will be reported to the ICEMA Medical Director on a monthly basis using an ICEMA approved registry.

VI. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

NSRC shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- Morbidity and mortality related to procedural complications.

- Tracking door-to-intervention times and adherence to minimum performance standards.

  ICEMA will determine current performance indicators. Any specific or additional performance indicators will be determined in collaboration with the Stroke CQI Committee.

- Active participation in ICEMA Stroke CQI Committee activities.

VII. PERFORMANCE STANDARDS

Compliance with the American Stroke Association Performance Measures as a Primary Stroke Center.

VIII. DESIGNATION

- The NSRC applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.

- Documentation of current accreditation as a Primary Stroke Center by TJC or HFAP shall be accepted in lieu of a formal site visit by ICEMA.

- Initial designation as a NSRC shall be in accordance with terms outlined in the agreement.

- Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of the NSRC designation.

IX. REFERENCE

Number	**Name**
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)

TACTICAL MEDICINE PROGRAM

I. PURPOSE

To provide medical oversight and continuous quality improvement and establish policies and procedures for EMS personnel assigned to Tactical Medicine Programs within the ICEMA region.

II. POLICY

1. Tactical Medicine Programs shall be developed and utilized in accordance with the "California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations" document that can be located on the EMSA website at emsa.ca.gov.

2. Tactical Medicine Programs and their medical personnel (Emergency Medical Technicians (EMTs), Advanced EMT (AEMTs), Paramedics (EMT-Ps), and Registered Nurses (RNs)) shall be integrated into the local EMS system, in coordination with ICEMA, the local Emergency Medical Services (EMS) Agency (POST, 2010).

3. Tactical medicine programs shall be reviewed and approved by ICEMA.

4. Administration of this policy applies to EMTs, AEMTs, EMT-Ps, and RNs providing medical services within an established EMS Agency and as part of a recognized Tactical Medical Program.

    a. The medical scope of practice for EMTs, AEMTs and EMT-Ps is consistent with Title 22, Division 9 and all ICEMA protocols.

5. Tactical Medicine Programs should designate a Tactical Medicine Program Director as defined within POST and EMSA guidelines.

6. Tactical Medicine Programs should designate a physician as a Tactical Medicine Medial Director "to provide medical direction, continuous quality improvement, medical oversight, and act as a resource for medical contingency planning" (POST, 2010).

7. Tactical Medicine Operational Programs should have components pertaining to planning, medical oversight, quality improvement and training as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.1-7).

8. Tactical Medicine Programs should include tactical medical personnel in mission planning and risk assessment to ensure appropriate assets are available for the identified mission as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.2).

III. PROCEDURE

1. All agencies that intend to provide a Tactical Medicine Program will:

   a. Submit an original application indicating the type of program. The Specialty and Optional Scope Program Application is available on the ICEMA website at ICEMA.net.

   b. Submit a copy of the proposed program to include all information as listed on the application.

   c. Provide a list of all RNs, EMTs and EMT-Ps assigned to the Tactical Medicine Program.

   d. Tactical medical personnel must be:

      1) EMT-Ps must be California licensed and accredited by ICEMA.

      2) EMTs and AEMTs must be California certified.

      3) RNs must be licensed as a Registered Nurse in California and an approved Flight Nurse, MICN, or EMT-P within the ICEMA region.

   e. Participate in ICEMA approved Continuous Quality Improvement process.

IV. TRAINING

Designated Tactical Emergency Medical Support (TEMS) personnel shall successfully complete all initial and ongoing recommended training provided by an approved tactical medicine training program as listed in the California POST/EMSA *Tactical Medicine Operational Programs and Standardized Training Recommendations* - March 2010 document.

V. DRUG AND EQUIPMENT LISTS

Equipment and supplies carried and utilized by Tactical Emergency Medical Support (TEMS) personnel shall be consistent with the items listed in the California POST/EMSA *Tactical Medicine Operational Programs and Standardized Training Recommendations* document. Equipment and supplies shall be based on the

appropriate level of personnel utilized for the particular Tactical Medicine Program (TEMS BLS or TEMS ALS).

The Tactical Medicine Program standard list of drugs and equipment carried by TEMS BLS or TEMS ALS medical personnel must be reviewed and approved by ICEMA prior to issue or use by EMT or EMT-P personnel.

TACTICAL MEDICINE OPERATIONAL EQUIPMENT RECOMMENDATIONS

Medications	BLS	ALS
Albuterol 2.5 mg with Atrovent 0.5 mg MDI		1
Aspirin 81 mg		1 bottle
Atropine Sulfate 1 mg preload		1
Dextrose 50% 25 gm preload		1
Diphenhydramine 50 mg		2
Epinephrine (1:1000) 1 mg		2
Epinephrine (1:10,000)1 mg preload		2
Glucagon 1 mg		1
Naloxone 2 mg preload		2
Nerve Agent Antidote (DuoDote)		1
Nitroglycerine 0.4 metered dose or tablets (tablets to be discarded 90 days after opening)		1
Normal Saline 500 ml		2
Ondansetron 4 mg IV/IM/oral tabs		4

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	BLS	ALS
Midazolam		20 mgs
Fentanyl		200 - 400 mcg

AIRWAY EQUIPMENT

Airway Equipment	BLS	ALS
Chest seal and Flutter Valve		1
End Tidal CO2 (device may be integrated into bag)		1
Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5 with stylet		1 each
ET Tube holder		1
King LTS-D Size 4 and 5	1 each if approved	1 each
Laryngoscope Kit		1
Nasopharyngeal Airways Adult	1 set	1 set
Needle Cricothyrotomy Device		1
Needle Thoracostomy Kit		1

Airway Equipment	BLS	ALS
Suction (hand held)	1	1
Ventilation Bag collapsible (BVM)	1	1

IV/MONITORING EQUIPMENT

IV/Needle/Syringes	BLS	ALS
AED (with waveform monitoring preferred)	1	1
AED Pads	1	1
Blood Pressure Cuff	1	1
IO Device and Needles		1
IV Needles 14-20 Gauge		1 of each
IV Start Kit		1
IV Tubing		1
Pulse Oximeter (optional)		1
Saline Flush		2
Saline Lock		2
Stethoscope	1	1
Syringes 3 cc, 5 cc, 10 cc		1 each

DRESSING AND SPLINTING

Dressing/Splints	BLS	ALS
CoTCCC - Recommended tourniquet system	1	1
Elastic compression dressing	1	1
Latex free gloves	1	1
N95 Mask	1	1
Occlusive dressing	1	1
Roller bandage	1	1
Splint - semi-ridged moldable	1	1
Sterile gauze pads	1	1
Tape	1	1
Trauma dressing	1	1
Trauma shears	1	1
Triangle bandage	1	1
Hemostatic impregnated gauze non-exothermic, i.e., Combat Gauze (optional)	2	2

MISCELLANEOUS EQUIPMENT

Miscellaneous Equipment	BLS	ALS
Litter	1	1
Patient care record	1	1
Personal protection equipment (PPE)	1	1
Triage tags	10	10

Miscellaneous Equipment	BLS	ALS
Tactical light	1	1
Eyeware	1	1
Rescue blanket	1	1
Self-heating blanket	1	1

EMERGENCY MEDICAL DISPATCH CENTER REQUIREMENTS *(San Bernardino County Only)*

I. PURPOSE

To establish ICEMA authorized Emergency Medical Dispatch (EMD) Centers to dispatch emergency medical services (EMS) resources and establish the minimum response levels of those resources.

Currently, Medical Priority Dispatch System™ (MPDS) is the only ICEMA recognized EMD program.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.200, 1797.204, and 1797.220.

III. DEFINITIONS

Emergency Medical Dispatch (EMD): The reception, evaluation, processing and provision of dispatch life support; management of requests for emergency medical assistance; ongoing evaluation and improvement of the emergency medical dispatch process.

Emergency Medical Dispatch (EMD) Centers: Any dispatching center receiving and dispatching calls for emergency medical services, which provide pre-arrival medical care instructions and/or tiered response resource management.

Emergency Medical Dispatcher: An individual certified by the National Academy of Emergency Medical Dispatch (NAEMD) providing pre-arrival instructions and/or tiered response management.

EMS Provider: First responder and/or Ambulance provider participating in the EMD program.

IV. DISPATCH OPERATIONS

- EMD Dispatch Centers shall:
  - Provide dispatch services necessary to receive and respond to requests for emergency and advanced life support (ALS) ambulance services and monitor system status.
  - Be approved by the State of California as a public safety answering point (PSAP).

- Receive and process calls for emergency medical assistance from primary and secondary 9-1-1 PSAPs.
- Provide required data and reports to ICEMA.

- Emergency Medical Dispatchers shall:
  - Determine the nature and severity of medical incidents consistent with MPDS protocols.
  - Dispatch appropriate EMS resources.
  - Provide post-dispatch and pre-arrival instructions to callers.
  - Notify responding personnel and agencies of pertinent information.
  - Monitor and track responding resources of their agency.
  - Coordinate with law enforcement, first responders and other EMS providers as needed and provide education to enhance cooperation between agencies.
  - Participate in the ICEMA Continuous Quality Improvement (CQI) process.

V. STAFFING

- The EMD Dispatch Center shall be staffed with sufficient NAEMD trained dispatchers to accomplish all dispatch and EMD functions as indicated by the CQI process.
- All dispatchers interrogating calls must be certified by the NAEMD.
- All emergency medical dispatchers shall receive the required amount of continuing dispatch education to meet NAEMD training standard.

VI. PROCEDURE

- Each dispatch center shall submit a completed application to ICEMA. This will include a response plan for each agency it services. Compliance with this policy will be reviewed by ICEMA every two (2) years. Any changes in service shall be reported to ICEMA immediately.
- All EMD Dispatch Centers that dispatch 9-1-1 medical response shall follow medical priority dispatch procedures that are compliant with NAEMD guidelines.

- All EMS providers using tiered response as detailed by NAEMD, shall provide the EMD Dispatch Center with a detailed response plan using the appropriate response codes that are compliant with NAEMD guidelines and ICEMA Reference #6130. The EMD Dispatch Center will then forward the response plan to ICEMA for review by the ICEMA Medical Director. Any changes must be authorized by ICEMA Medical Director.

- ICEMA local medical control approved cards are as follows:

MPDS Card #	Card Name	Approved Yes/No	Description	Special Instructions
Card 9	Cardiac Arrest/Death	Yes	Authorized based on current protocols.	Follow ICEMA Reference #12010 and #12020.
Card 10	Aspirin Diagnostic and Instruction	Yes	Use of Aspirin prior to EMS arrival.	Approved for use throughout the ICEMA region.
Card 24	Pregnancy/Childbirth	Yes	Authorized based on current protocols.	Follow ICEMA Reference #14080.
Card 28	Stroke	Yes	Authorized based on current protocols.	Follow ICEMA Reference #11110.
Card 33	Transfer	No		

VII. CQI PLAN

- EMD Dispatch Centers shall submit a CQI plan to ICEMA following the model of the NAEMD. Data will be submitted at a frequency as determined by the CQI Committee to ICEMA as outlined in the CQI plan. Specific additional indicators may be determined by ICEMA as needed.

- EMD Dispatch Centers shall participate on the ICEMA EMD CQI Committee. Meetings will be held as needed to review the QI data and will include dispatch supervisors, data entry personnel, dispatch representatives and ICEMA representatives.

- Updates to the NAEMD authorized dispatch system must be implemented in a timely manner as soon as the education and hardware are completed and compatible and documentation of the re-training must be sent to ICEMA once complete.

- A quarterly QI report will be submitted to ICEMA as per the CQI plan. Indicators and education that were reviewed and completed will be documented in this report.

VIII. REFERENCE

Number	**Name**
6130	Medical Priority Dispatch Minimum Response assignments for Emergency Medical Dispatch (EMD) Categories

MEDICAL PRIORITY DISPATCH MINIMUM RESPONSE ASSIGNMENTS FOR EMERGENCY MEDICAL DISPATCH (EMD) CATEGORIES

I. PURPOSE

The purpose of this policy is to establish approved Medical Priority Dispatch System™ (MPDS) response and mode assignments for use by authorized Emergency Medical Dispatch (EMD) Centers.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.220

III. DEFINITIONS

Ambulance: An emergency basic life support (BLS) or advanced life support (ALS) ambulance.

Ambulance Provider: An entity properly permitted to operate an emergency ALS ambulance service in San Bernardino County.

Emergency Medical Dispatch (EMD): The reception, evaluation, processing and provision of dispatch life support; management of requests for emergency medical assistance; and ongoing evaluation and improvement of the emergency medical dispatch process.

Emergency Medical Dispatch (EMD) Centers: Any dispatching center receiving and dispatching calls for emergency medical services providing pre-arrival medical care instructions and/or tiered response resource management.

First Responder Vehicle: An emergency basic life support (BLS) or advanced life support (ALS) non-transport vehicle operated by an EMS provider.

First Responder Provider: An organization authorized by ICEMA to participate in the EMS system that is the initial contact for patients in the prehospital setting.

IV. POLICY

- EMD Centers shall dispatch EMS resources to medical emergencies and manage their response in accordance w/ the response level established by this policy.

- First responder and ambulance resources shall comply w/ instructions from an authorized EMD Center to upgrade, cancel, or reduce their response mode.

- ICEMA approved MPDS response and mode assignments for use by authorized EMD Centers are as follows:

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
Card 1	**Abdominal Pain**	D-1	Not alert	X	
		C-1	Suspected aortic aneurysm	X	
		C-2	Known aortic aneurysm	X	
		C-3	Fainting or near fainting	X	
		C-4	Females w/ fainting or near fainting	X	
		C-5	Males w/ pain above navel	X	
		C-6	Females w/ pain above navel	X	
		A-1	Abdominal pain		X
Card 2	**Allergies/Stings/Bites**	E-1	Ineffective breathing	X	
		D-1	Not alert	X	
		D-2	Difficulty speaking between breaths	X	
		D-3	Swarming attack (bees, wasps)	X	
		D-4	Snake bite	X	
		C-1	Difficulty breathing or swallowing	X	
		C-2	History of severe allergic reaction	X	
		B-1	Unknown status	X	
		A-1	No difficulty breathing or swallowing (rash, hives, or itching may be present)		X
		A-2	Spider bite		X
Card 3	**Animal Bites/Attacks**	D-1	Unconscious or arrests	X	
		D-2	Not alert	X	
		D-3	Chest or neck injury(w/ difficulty breathing)	X	
		D-4	Dangerous body area	X	
		D-5	Large animal	X	
		D-6	Exotic animal	X	
		D-7	Attack or multiple animals	X	
		B-1	Possibly dangerous body area	X	
		B-2	Serious hemorrhage	X	
		B-3	Unknown status/other code not applicable	X	
		A-1	Not dangerous body area		X
		A-2	Non-recent		X
		A-3	Superficial bites		X
Card 4	**Assault/Sexual Assault**	D-1	Unconscious or arrest	X	
		D-2	Not alert	X	
		D-3	Chest or neck injury (w/ difficulty breathing)	X	
		D-4	Multiple victims	X	
		B-1	Possibly dangerous body area	X	
		B-2	Serious hemorrhage	X	
		B-3	Unknown status/ other code not applicable	X	
		A-1	Not dangerous body area		X

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		A-2	Non-recent		X
Card 5	**Back Pain (Non-trauma)**	D-1	Not alert	X	
		C-1	Suspected aortic aneurysm	X	
		C-2	Known aortic aneurysm	X	
		C-3	Fainting or near fainting	X	
		A-1	Non-traumatic back pain		X
		A-2	Non-recent		X
Card 6	**Breathing Problems**	E-1	Ineffective breathing	X	
		D-1	Not alert	X	
		D-2	Difficulty speaking between breaths	X	
		D-3	Changing color	X	
		D-4	Clammy	X	
		C-1	Abnormal breathing	X	
Card 7	**Burns (Scald/ Explosion)**	D-1	Multiple victims	X	
		D-2	Unconscious or arrest	X	
		D-3	Not alert	X	
		D-4	Difficulty speaking between breaths	X	
		C-1	Building fire	X	
		C-2	Difficulty breathing	X	
		C-3	Burns > 18% body area	X	
		C-4	Significant facial burns	X	
		B-1	Blast injuries (w/o priority symptoms)	X	
		B-2	Unknown status	X	
		A-1	Burns < 18%	X	
	FIRE ONLY	A-2	Fire alarm (unknown situation)		
		A-3	Sunburn or minor burn		X
Card 8	**CO/Inhalation/ HazMat**	D-1	Unconscious or arrest	X	
		D-2	Not alert	X	
		D-3	Difficulty speaking between breaths	X	
		D-4	Multiple victims	X	
		D-5	Unknown status	X	
		C-1	Alert w/ difficulty breathing	X	
		B-1	Alert w/o difficulty breathing	X	
	FIRE ONLY	OMEGA-1	CO detector w/o symptoms		
Card 9	**Cardiac or Respiratory Arrest Death**	E-1	Not breathing at all	X	
		E-2	Breathing uncertain (agonal)	X	
		E-3	Hanging	X	
		E-4	Strangulation	X	
		E-5	Suffocation	X	
		E-6	Underwater	X	
		D-1	Ineffective breathing	X	
		D-2	Obvious or expected death	X	
		B-1	Obvious death	X	

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		OMEGA-1	Expected death (DNR, terminal)	X	
Card 10	**Chest Pain (Non-traumatic)**	D-1	Not alert	X	
		D-2	Difficulty speaking between breaths	X	
		D-3	Changing color	X	
		D-4	Clammy	X	
		C-1	Abnormal breathing	X	
		C-2	Heart attack or angina history	X	
		C-3	Cocaine	X	
		C-4	Breathing normally ≥ 35	X	
		A-1	Breathing normally < 35	X	
Card 11	**Choking**	E-1	Complete obstruction	X	
		D-1	Abnormal breathing	X	
			(Partial obstruction)	X	
		D-2	Not alert	X	
		A-1	Not choking now		X
Card 12	**Convulsion/Seizures**	D-1	Not breathing at all	X	
		D-2	Continuous or multiple seizures	X	
		D-3	Agonal/ineffective breathing	X	
		D-4	Effective breathing not verified ≥ 35	X	
		C-1	Focal seizures not alert	X	
		C-2	Pregnancy	X	
		C-3	Diabetic	X	
		B-1	Effective breathing not verified < 35	X	
		A-1	Not seizing now and breathing	X	
		A-2	Focal seizures alert	X	
		A-3	Impending seizure	X	
Card 13	**Diabetic Problems**	D-1	Unconscious	X	
		C-1	Not alert	X	
		C-2	Abnormal behavior	X	
		C-3	Abnormal breathing	X	
		A-1	Alert and behaving normally		X
Card 14	**Drowning (Near)/ Diving Accident**	D-1	Unconscious	X	
		D-2	Not alert	X	
		D-3	Diving or suspected neck injury	X	
		D-4	Scuba accident	X	
		C-1	Alert w/ abnormal breathing	X	
		B-1	Alert and breathing normally	X	
		B-2	Unknown status	X	
		A-1	Alert and breathing normally	X	

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
Card 15	**Electrocution/ Lightning**	E-1	Not breathing/ineffective breathing	X	
		D-1	Unconscious	X	
		D-2	Not disconnected from power	X	
		D-3	Power not off or hazard present	X	
		D-4	Extreme fall ≥ 30 feet)	X	
		D-5	Long fall	X	
		D-6	Not alert	X	
		D-7	Abnormal breathing	X	
		D-8	Unknown status	X	
		C-1	Alert and breathing normally	X	
Card 16	**Eye Problems/Injuries**	D-1	Not alert	X	
		B-1	Severe eye injuries	X	
		A-1	Moderate eye injuries	X	
		A-2	Minor eye injuries		X
		A-3	Medical eye problems		X
Card 17	**Falls**	D-1	Extreme fall ≥ 30 feet)	X	
		D-2	Unconscious or arrest	X	
		D-3	Not alert	X	
		D-4	Chest or neck injury w/ difficulty breathing	X	
		D-5	Long fall	X	
		B-1	Possibly dangerous body area	X	
		B-2	Serious hemorrhage	X	
		B-3	Unknown status	X	
		A-1	Not dangerous body area		X
		A-2	Non-recent		X
	FIRE ONLY	A-3	Public assist		
Card 18	**Headache**	C-1	Not alert	X	
		C-2	Abnormal breathing	X	
		C-3	Speech problems	X	
		C-4	Sudden onset of severe pain	X	
		C-5	Numbness	X	
		C-6	Paralysis	X	
		C-7	Change in behavior (< 3 hours)	X	
		B-1	Unknown status	X	
		A-1	Breathing normally		X
Card 19	**Heart Problems/ A.I.C.D**	D-1	Not alert	X	
		D-2	Difficulty speaking between breaths	X	
		D-3	Changing color	X	
		D-4	Clammy	X	
		D-5	Resuscitated and/or defibrillation	X	
		C-1	Firing of A.I.C.D.	X	
		C-2	Abnormal breathing	X	
		C-3	Chest pain ≥ 35 minutes	X	

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		C-4	Cardiac history	X	
		C-5	Cocaine	X	
		C-6	Heart rate < 50 bpm or > 130 bpm (w/o symptoms)	X	
		C-7	Unknown status	X	
		A-1	Heart rate > 50 bpm and < 130 bpm w/o symptoms)	X	
		A-2	Chest pain ≤ 35 w/o symptoms	X	
Card 20	**Heat/Cold Exposures**	D-1	Not alert	X	
		D-2	Multiple victims	X	
		C-1	Heart attack or angina history	X	
		B-1	Change in skin color	X	
		B-2	Unknown status	X	
		A-1	Alert		X
Card 21	**Hemorrhage/ Lacerations**	D-1	Unconscious or alert	X	
		D-2	Not alert	X	
		D-3	Dangerous hemorrhage	X	
		D-4	Abnormal breathing	X	
		C-1	Hemorrhage through tubes	X	
		C-2	Hemorrhage of dialysis fistula	X	
		B-1	Possibly dangerous hemorrhage	X	
		B-2	Serious hemorrhage	X	
		B-3	Bleeding disorder	X	
		B-4	Blood thinner	X	
		A-1	Not dangerous hemorrhage		X
		A-2	Minor hemorrhage		X
Card 22	**Inaccessible Incident/ Other Entrapments**	D-1	Mechanical/machinery entrapment	X	
		D-2	Trench collapse	X	
		D-3	Structure collapse	X	
		D-4	Confined space entrapment	X	
		D-5	Inaccessible terrain situation	X	
		D-6	Mudslide/avalanche	X	
		B-1	No longer trapped unknown injuries	X	
		B-2	Peripheral entrapment only	X	
		B-3	Unknown status	X	
	FIRE ONLY	A-1	No longer trapped no injuries		
Card 23	**Overdose/Poisoning (Ingestion)**	D-1	Unconscious	X	
		D-2	Changing color	X	
		C-1	Not alert	X	
		C-2	Abnormal breathing	X	
		C-3	Antidepressants (tricyclic)	X	
		C-4	Cocaine, methamphetamine	X	
		C-5	Narcotics (heroin)	X	

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		C-6	Acid or alkali (lye)	X	
		C-7	Unknown status	X	
		C-8	Poison control	X	
		B-1	Overdose w/o symptoms		X
	POISON CONTROL CONTACT	OMEGA-1	Poisoning w/o symptoms		
Card 24	**Pregnancy/Childbirth/ Miscarriage**	D-1	Breech or cord	X	
		D-2	Head visible/out	X	
		D-3	Imminent delivery > 20 weeks)	X	
		D-4	3rd trimester hemorrhage	X	
		D-5	High risk complications	X	
		D-6	Baby born (complications w/ baby)	X	
		D-7	Baby born (complications w/ mother)	X	
		C-1	2nd trimester hemorrhage or miscarriage	X	
		C-2	1st trimester serious hemorrhage	X	
		C-3	Baby born no complications	X	
		B-1	Labor delivery not imminent greater 5 months/20 weeks	X	
		B-2	Unknown status	X	
		A-1	1st trimester hemorrhage or miscarriage		X
		OMEGA-1	Waters broken (no contractions)		X
Card 25	**Psychiatric/Abnormal Behavior/Suicide Attempt**	D-1	Not alert	X	
		D-2	Dangerous hemorrhage	X	
		B-1	Serious hemorrhage	X	
		B-2	Non-serious or minor hemorrhage	X	
		B-3	Threatening suicide	X	
		B-4	Jumper (threatening)	X	
		B-5	Near hanging, strangulations Or suffocation	X	
		B-6	Unknown status	X	
	POLICE ONLY	A-1	Non-suicidal and alert		
	POLICE ONLY	A-2	Suicidal (not threatening) and alert		
Card 26	**Sick Person (Specific Diagnosis)**	D-1	Not alert	X	
		C-1	Altered level of consciousness	X	
		C-2	Abnormal breathing	X	
		C-3	Sickle cell crisis	X	
		B-1	Unknown status	X	
		A-1	No priority symptoms		X
		A-2	Non-priority complaints		X
		OMEGA-1	This code is not in use		X

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		OMEGA-2-28 (EXC 9)	Non-priority complaints		X
	FIRE ONLY	Omega 9	Cut off ring request		
Card 27	**Stab/Gunshot/ Penetrating Trauma**	D-1	Unconscious or arrest	X	
		D-2	Not alert	X	
		D-3	Central wounds	X	
		D-4	Multiple wounds	X	
		D-5	Multiple victims	X	
		B-1	Non-recent (> 6 hours)	X	
		B-2	Known single peripheral wound	X	
		B-3	Serious hemorrhage	X	
		B-4	Unknown status	X	
		B-5	Obvious death	X	
		A-1	Non-recent (> 6 hours) wounds (w/o priority symptoms)		X
Card 28	**Stroke (CVA)**	C-1	Not alert	X	
		C-2	Abnormal breathing	X	
		C-3	Speech problems	X	
		C-4	Numbness, paralysis, or movement	X	
		C-5	Vision problems	X	
		C-6	Sudden onset of severe headache	X	
		C-7	Stroke history	X	
		C-8	Breathing normally ≥ 35	X	
		B-1	Unknown status	X	
		A-1	Breathing normally < 35	X	
Card 29	**Traffic/ Transportation Incidents**	D-1	Major incident	X	
		D-2	High mechanism	X	
		D-3	Hazmat	X	
		D-4	Pinned (trapped) victim	X	
		D-5	Not alert	X	
		B-1	Injuries	X	
		B-2	Serious hemorrhage	X	
		B-3	Other hazards	X	
		B-4	Unknown status	X	
		A-1	1st party caller w/ injury to not dangerous body part		X
	POLICE ONLY	OMEGA1	No injuries		
Card 30	**Traumatic Injuries (Specific)**	D-1	Unconscious or arrest	X	
		D-2	Not alert	X	
		D-3	Chest or neck injury(w/ difficulty breathing)	X	
		B-1	Possibly dangerous body part	X	
		B-2	Serious hemorrhage	X	

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		A-1	Not dangerous body area		X
		A-2	Non-recent (> 6 hours)		X
Card 31	**Unconscious/Fainting (Near)**	E-1	Ineffective breathing	X	
		D-1	Unconscious - agonal/ ineffective breathing	X	
		D-2	Unconscious - effective breathing	X	
		D-3	Not alert	X	
		D-4	Changing color	X	
		C-1	Alert w/ abnormal breathing	X	
		C-2	Fainting episode and alert ≥ 35 (w/ cardiac history)	X	
		C-3	Females 12-50 w/ abdominal pain	X	
		A-1	Fainting episode and alert ≥ 35 (w/o cardiac history)	X	
		A-2	Fainting episode and alert < 35 (w/ cardiac history)	X	
		A-3	Fainting episode and alert < 35 (w/o cardiac history)		X
Card 32	**Unknown Problem (Man Down)**	D-1	Life status questionable	X	
		B-1	Standing, sitting, moving or talking	X	
		B-2	Medical alarm (no patient information)	X	
		B-3	Unknown status	X	
		B-4	Caller's language not understood	X	
Card 33	**Transfer/Interfaculty/ Palliative Care**	D-1	Suspected cardiac or respiratory arrest	X	
		D-2	Just resuscitated or defibrillated	X	
		C-1	Not alert	X	
		C-2	Abnormal breathing (acute onset)	X	
		C-3	Significant hemorrhage or shock	X	
		C-4	Possible acute heart problems or MI	X	
		C-5	Acute severe pain	X	
		C-6	Emergency response requested	X	
		A-1	Acuity I (no priority symptoms)	X	
		A-2	Acuity II (no priority symptoms)	X	
		A-3	Acuity III (no priority symptoms	X	
Card 34	**Automatic Crash Notification (ACN)**	D-1	High mechanism		
		D-2	Unconscious or not alert		

MPDS Card #	Card Name	Level #	Determinant Descriptors	ALS/1st	BLS/1st
		D-3	Not breathing/ineffective breathing		
		D-4	Life status questionable		
		B-1	Injuries involved		
		B-2	Multiple victims (one unit)		
		B-3	Multiple victims (additional units)		
		B-4	Airbag/other automatic sensor		
		B-5	Unknown situation/other codes (not applicable)		
		A-1	Not dangerous injuries (1st party and single occupant)		
		OMEGA1	No injuries (refer to police)		

V. REFERENCE

Number	**Name**
6120	Emergency Medical Dispatch Center Requirements (*San Bernardino County Only)*

SMOKE INHALATION/CO EXPOSURE/SUSPECTED CYANIDE TOXICITY (Expanded Scope Specialty Program)

I. PURPOSE

To identify and treat smoke inhalation and suspected cyanide toxicity.

II. AUTHORITY

California Health and Safety Code, Sections 1797.172 and 1797.185

California Code of Regulations, Title 22, Division 9, Chapter 4

III. FIELD ASSESSMENT/TREATMENT INDICATORS

- Indicators
  - Exposure to fire and smoke particularly in an enclosed-space structure fires.
  - Hydrogen cyanide concentration measured in the air does not accurately correlate to patient's level of exposure and toxicity. Consider possibility of carbon monoxide (CO) and cyanide exposure/toxicity in any patient (or unprotected EMS field personnel) with smoke inhalation.
- Cyanide Toxicity
  - Initial signs and symptoms are non-specific and may include; headache, dizziness, nausea, vomiting, confusion, and syncope.
  - Worsening signs and symptoms may include; altered level of consciousness (ALOC), hypotension, shortness of breath, seizures, cardiac dysrhythmias, and cardiac arrest.
  - The "bitter almond" smell on the breath of a cyanide-poisoned patient is neither sensitive nor specific and should not be considered in making the assessment.
- Carbon Monoxide Poisoning
  - Initial signs and symptoms are non-specific and may include; flu like symptoms, dizziness, severe headache, nausea, sleepiness, weakness and disorientation.

- Worsening signs and symptoms may include; blurred vision, shortness of breath, and altered level of consciousness.

IV. ALS INTERVENTIONS

- Remove patient from exposure area.
- Administer 100% oxygen via non-rebreather mask.
- Monitor pulse oximetry (SpO_2) though values may be unreliable in patients suffering from smoke inhalation.
- Monitor Carboxyhemoglobin (SpCO) levels. (SpCO monitor is required for participation in this Specialty program.)
- IV access, consider fluid bolus of 300cc NS.
- Patients exhibiting signs and symptoms of cyanide toxicity which persist after treatment with 100% oxygen therapy should be treated rapidly with the Cyanokit.
  - Administer Hydroxocobalamin.
    - Dosage: 5 gm IV over 15 minutes. May repeat one (1) time with base hospital orders. Second dose given over 15 minutes to 2 hours depending on the response to the first dose.
    - Reconstitute: Place the vial in an upright position. Add 200 mL of 0.9% Sodium Chloride Injection (not included in the kit) to the vial using the transfer spike. Fill to the line.
    - Mix: The vial should be repeatedly inverted or rocked, not shaken, for at least 60 seconds prior to infusion.
    - Infuse Vial: Use vented intravenous tubing, hang and infuse over 15 minutes.
- Use BVM with airway adjuncts as needed. Consider advanced airway if indicated.
- Refer to ICEMA Reference #11010 - Adult Respiratory Emergencies, for treatment of bronchospasm as indicated by wheezing
- Ensure rapid transport to closest receiving emergency department. In patients with SpCO of > 25% (> 15% if pregnant) or signs and symptoms of worsening CO poisoning, consider transport to a hyperbaric facility.

- Hyperbaric Medicine
  - Arrowhead Regional Medical Center
  - Loma Linda University Medical Center
  - Redlands Community Hospital
  - St. Mary Regional Medical Center

V. REFERENCE

Number	**Name**
11010	Adult Respiratory Emergencies

TRIAL STUDY PARTICIPATION

I. PURPOSE

To define the requirements for Emergency Medical Services (EMS) providers or hospitals to participate in California EMS Authority (EMSA) approved trial studies in the Inland Counties Emergency Medical Agency (ICEMA) region.

II. ELIGIBILITY

Participating EMS providers and hospitals must:

- Designate an EMS Coordinator or Continuous Quality Improvement (CQI) Coordinator respectively.
- EMS providers must be current participants on the ICEMA Data System and complete all the required fields on the electronic patient care record (ePCR) for the duration of the study.
- EMS or CQI Coordinators must review all enrolled cases within 24 hours and report any adverse effects to ICEMA immediately.
- All EMS field personnel and hospital staff participating in the trial study must successfully complete all educational offerings or competencies for the duration of the study.
- Hospitals must compile and submit all relevant data elements as requested by ICEMA.
- Due to the nature of these trial studies and safety concerns, the EMS or CQI Coordinators must participate in all Trial Study CQI Review meetings and incident reviews of enrolled trial study cases. Additionally, all personnel directly involved in these trial studies may be required to attend and participate in Trial Study CQI Review meetings.
- EMS providers and hospitals must commit to purchasing and maintaining, at their cost, an adequate supply of the medication and/or equipment used in the trial study.

III. PROCEDURE:

- EMS or CQI Coordinator must notify ICEMA, in writing, expressing their interest in participating in the trial study.

- EMS or CQI Coordinator must provide rosters of all personnel documenting completion of educational offerings and/or competencies within 10 days of completion.

- EMS providers and hospitals must sign the Condition of Participation form acknowledging the terms of the trial study.

BLS/LALS/ALS STANDARD DRUG & EQUIPMENT LIST

Each ambulance and first responder unit shall 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	LALS	ALS Non-Transport	ALS Transport
Adenosine (Adenocard) 6 mg			1	1
Adenosine (Adenocard) 12 mg			2	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg		4 doses	4 doses	4 doses
Albuterol MDI with spacer		1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY	1 SPECIALTY PROGRAMS ONLY
Aspirin, chewable - 81 mg tablet		2	1 bottle	1 bottle
Atropine 1 mg preload			2	2
Calcium Chloride 1 gm preload			1	1
Dextrose 10% in 250 ml Water (D10W) *		2	2	2
Diphenhydramine (Benadryl) 50 mg			1	1
Dopamine 400 mg			1	1
Epinephrine 1:1000 1 mg		2	2	2
Epinephrine 1:10,000 1 mg preload			3	3
Glucagon 1 mg		1	1	1
Glucose paste	1 tube	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg			4	4
Irrigating Saline and/or Sterile Water (1000 cc)	2	1	1	2
Lidocaine 100 mg			3	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W			1	1
Lidocaine 2% Intravenous solution			1	1
Lidocaine 2% (Viscous) dose			1	1
Magnesium Sulfate 10 gm			1	1
Naloxone (Narcan) 2 mg preload		2	2	2
Nitroglycerine - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening)		2	1	2
Normal Saline for Injection (10 cc)		2	2	2

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Normal Saline 100 cc			1	2
Normal Saline 250 cc			1	1
Normal Saline 500 ml and/or 1000 ml		2000 ml	3000 ml	6000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)			4	4
Ondansetron (Zofran) 4 mg IM/ IV			4	4
Phenylephrine HCL - 0.5 mg per metered dose			1 bottle	1 bottle
Sodium Bicarbonate 50 mEq preload			2	2

CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange Controlled Substance Medications MUST BE DOUBLE LOCKED	BLS	LALS	ALS Non-Transport	ALS Transport
Fentanyl			200-400 mcg	200-400 mcg
Midazolam			20-40mg	20-40mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
BAAM Device			1	2
CPAP circuits - all manufacture's available sizes	1 (if CPAP is carried)	1 (if CPAP is carried)	1 each	2 each
End-tidal CO2 device - Pediatric and Adult (may be integrated into bag)			1 each	1 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
ET Tube holders - adult		1 each	1 each	2 each
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	2 each SPECIALTY PROGRAMS ONLY	1 each	1 each	2 each
King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange)	2 each SPECIALTY PROGRAMS ONLY	1 each	1 each	2 each
Mask - Adult & Pediatric non-rebreather oxygen mask	2 each	2 each	2 each	2 each
Mask - Infant Simple Mask	1	1	1	1
Nasal cannulas - pediatric and adult	2 each	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr			1 each	1 each
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	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

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Oropharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Rigid tonsil tip suction	1		1	1
Small volume nebulizer with universal cuff adaptor		2	2	2
Suction Canister	1		1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each		1 each	1 each
Ventilation Bags - Infant 250 ml Pediatric 500 ml (or equivalent) Adult	 1 1 1	 1 1 1	 1 1 1	 1 1 1
Water soluble lubricating jelly		1	1	1

Non-Exchange Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Ambulance oxygen source -10 L /min for 20 minutes	1			1
Flashlight/penlight	1	1	1	1
Laryngoscope 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
Manual powered suction device		1		
Portable oxygen with regulator - 10 L /min for 20 minutes	1	1	1	1
Portable suction device (battery operated)	1		1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1	1
Stethoscope	1	1	1	1
Wall mount suction device	1 (BLS TRANSPORT ONLY)			1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Conductive medium or Pacer/Defibrillation pads			2 each	2 each
Disposable Tourniquets		2	2	2
ECG electrodes			20	20
EZ-IO Driver			1 each	1 each
EZ-IO Needles: 25 mm 45 mm			 2 each 1 each	 2 each 1 each
Glucose monitoring device with compatible strips and		1	1	1

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
OSHA approved single use lancets				
3-way stopcock with extension tubing			2	2
IV Catheters - sizes 14, 16, 18, 20, 22, 24		2 each	2 each	2 each
Macrodrip Administration Set Microdrip Administration Set (60 drops /cc)		3 1	3 1	3 2
Mucosal Atomizer Device (MAD) for nasal administration of medication		2	2	4
Pressure Infusion Bag (disposable)		1	1	1
Razors		1	2	2
Safety Needles - 20 or 21gauge and 23 or 25 gauge		2 each	2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2	2
Sterile IV dressing		2	2	2
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc catheter tip		2 each		
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc, 20 cc, 60 cc catheter tip			2 each	2 each

Non-Exchange IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
12-lead ECG Monitor and Defibrillator with TCP and printout			1	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant (one of each size)	1	1	1	1
Capnography monitor and supplies, may be integrated in the cardiac monitor			1	1
Needle disposal system (OSHA approved)		1	1	1
Thermometer - Mercury Free with covers	1	1	1	1

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	LALS	ALS Non-Transport	ALS Transport
AED/defib pads - Adult (1), Pediatric (1)	1 each	1 each		
Ammonia Inhalants			2	2
Automatic CPR device (FDA approved)	1	1	1	1
Automatic ventilator (ICEMA approved)			1	1
Backboard padding	1	1	1	1
Buretrol			1	1
Chemistry profile tubes			3	3
CPAP - (must be capable of titrating pressure between 2 and 15 cm H_2O)	1 (optional)	1 (optional)	1	1
CyanoKit (Specialty Program Only)			1	1
EMS Tourniquet	1		1	1
Gum Elastic intubation stylet			2	2

Non-Exchange Optional Equipment/Medications	BLS	LALS	ALS Non-Transport	ALS Transport
Hemostatic Dressings *	1	1	1	1
IO Needles - Manual, Adult and Pediatric, Optional		Pediatric sizes only or EZ-IO needles and drivers	1 each	1 each
IV infusion pump			1	1
IV warming device		1	1	1
Manual IV Flow Rate Control Device			1	1
Manual powered suction device	1	1	1	1
Multi-lumen peripheral catheter			2	2
Needle Thoracostomy Kit (prepackaged)			2	2
Pulse Oximetry device	1			
Translaryngeal Jet Ventilation Device			1	1
Vacutainer			1	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are "packaged" in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4"x4"pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Exchanged Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
Adhesive tape - 1 inch	2	2	2	2
Air occlusive dressing	1	1	1	1
Ankle and wrist restraints, soft ties acceptable	1		1	1
Antiseptic swabs/wipes		10	10	10
Bedpan or fracture pan Urinal	1(BLS TRANSPORT UNITS ONLY 1(BLS TRANSPORT UNITS ONLY			1 1
Cervical Collars - Rigid Pediatric and Adult all sizes or Cervical Collars - Adjustable Adult and Pediatric	2 each 2 each	2 each 2 each	2 each 2 each	2 each 2 each
Cold Packs	2	2	2	2

Exchanged Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
Emesis basin or disposable bags and covered waste container	1	1	1	1
Head immobilization device	2	2	2	2
OB Kit	1	1	1	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	2	4
Provodine/Iodine swabs/wipes or antiseptic equivalent		4	10	10
Roller bandages - 4 inch	6	3	3	6
Sterile bandage compress or equivalent	6	2	2	6
Sterile gauze pads - 4x4 inch	4	4	4	4
Sterile sheet for Burns	2	2	2	2
Universal dressing 10x30 inches	2	2	2	2

Non-Exchange Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
800 MHz Radio		1	1	1
Ambulance gurney	1(BLS TRANSPORT UNITS ONLY			1
Bandage shears	1	1	1	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2	1	2	2
Drinkable water in secured plastic container or equivalent	1 gallon			1 gallon
Long board with restraint straps	1	1	1	1
Pediatric immobilization board	1	1	1	1
Pillow, pillow case, sheets and blanket	1 set (BLS TRANSPORT UNITS ONLY			1 set
Short extrication device	1	1	1	1
Straps to secure patient to gurney	1 set (BLS TRANSPORT UNITS ONLY			1 set
Traction splint	1	1	1	1
Triage Tags - CAL Chiefs or ICEMA approved	20	20	20	20

EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

Each Aircraft shall 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	AMOUNT
Adenosine (Adenocard) 6 mg	1
Adenosine (Adenocard) 12 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg	3 doses
Aspirin, chewable - 81 mg tablet	1 bottle
Atropine 1 mg preload	2
Calcium Chloride 1 gm preload	1
Dextrose 10% in 250 ml Water (D10W) *	2
Diphenhydramine (Benadryl) 50 mg	1
Dopamine 400 mg	1
Epinephrine 1:1,000	2
Epinephrine 1:10,000	2
Glucagon 1 mg	1
Glucopaste	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg	3
Lidocaine 100 mg	3
Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W	1 gm
Lidocaine 2% Intravenous solution	1
Lidocaine 2% (Viscous)	1 dose
Magnesium Sulfate 10 gms	1
Naloxone (Narcan) 2 mg preload	2
Nitroglycerin - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening.)	1
Normal Saline for Injection (10 cc)	2
Normal Saline 250 ml	1
Normal Saline 500 ml and/or 1000 ml	2000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)	4
Ondansetron (Zofran) 4 mg IM/ IV	4
Phenylephrine HCL - 0.5 mg per metered dose	1 bottle
Sodium Bicarbonate 50 mEq preload	2

CONTROLLED SUBSTANCE MEDICATIONS-MUST BE DOUBLE LOCKED	AMOUNT
Fentanyl	200-400 mcg
Midazolam	20-40 mg

AIRWAY/SUCTION EQUIPMENT	AMOUNT
Aircraft Oxygen source -10 L /min for 20 minutes	1
BAAM Device	1
C-PAP circuits - all manufacture's available sizes	1 each
End-tidal CO2 device - pediatric and adult (may be integrated into bag)	1 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
ET Tube holders - adult	1 each
Flashlight/penlight	1
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	1 each
King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange)	1 each
Laryngoscope handle with batteries - or 2 disposable handles	1
Laryngoscope blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Magill Forceps - 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 *or* Needles for procedure 10, 12, 14 and/or16 gauge	1 each 2 each
Non Re-Breather O_2 Mask - Pediatric and Adult, Infant Simple Mask	2 each
One way flutter valve with adapter or equivalent	1
Oropharyngeal Airways - infant, child, and adult	1 each
Portable Oxygen with regulator - 10 L /min for 20 minutes	1
Portable suction device (battery operated) *and/or* Wall mount suction device	1 each
Pulse Oximetry device	1
Small volume nebulizer with universal cuff adaptor	1
Stethoscope	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags - Infant 250 ml, Pediatric 500 ml and Adult 1 L	1 each
Water soluble lubricating jelly	1
Ridged tonsil tip suction	1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT	AMOUNT
12-Lead ECG Monitor and Defibrillator with TCP and printout	1
800 MHz Radio	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant	1 set
Capnography monitor and supplies, may be integrated in the cardiac monitor	1
Conductive medium *or* Adult and Pediatric Pacer/Defibrillation pads	2 each
ECG - Pediatric and Adult	20 patches
EZ IO Needles and Driver 25 mm and 45 mm	2 each 1 each
3-way stopcock with extension tubing	2
IO Needles - Manual, Adult and Pediatric, Optional	1 each
IV Catheters - sizes 14, 16, 18, 20, 22, 24	2 each
Glucose monitoring device	1
Macrodrip Administration Set Microdrip Administration Set (60 drops/ml)	3 1
Mucosal Atomizer Device (MAD) for nasal administration of medication	4
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Safety Needles - 20 or 21 gauge and 23 or 25 gauge	2 each
Saline Lock	2
Syringes w/wo safety needles - 1 ml, 3 ml, 10 ml, 20 ml	2 each
Syringe - 60 ml catheter tip	2
Thermometer - Mercury free with covers	1

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Adhesive tape - 1 inch	2
Air occlusive dressing	1
Aircraft stretcher or litter system with approved FAA straps that allows for Axial Spinal Immobilization	1
Ankle and wrist restraints, soft ties acceptable	1
Antiseptic swabs/wipes	
Bandage shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2
Cervical Collars - Rigid Pediatric & Adult all sizes *or* Cervical Collars - Adjustable Adult and Pediatric	1 each 1 each
Emesis basin or disposable bags and covered waste container	1
Head immobilization device	1
OB Kit	1
Pneumatic or rigid splints capable of splinting all extremities	4
Provodine/Iodine swabs/wipes or antiseptic equivalent	
Roller bandages - 4 inch	3
Sterile bandage compress or equivalent	6
Sterile gauze pads - 4x4 inch	4

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Sterile Sheet for Burns	2
Traction splint	1
Universal Dressing 10x30 inches	2

OPTIONAL EQUIPMENT/MEDICATIONS	Amount
Ammonia Inhalants	2
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
Chemistry profile tubes	3
CyanoKit (Specialty Program Only)	SPECIALTY PROGRAMS ONLY
D5W in bag	1
Hemostatic Dressing *	1
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Medical Tourniquet	1
Needle Thoracostomy Kit (prepackaged)	2
Pediatric immobilization board	1
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
  - Quick Clot®, Combat Gauze® LE
  - Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
  - Celox® Gauze, Z-Fold Hemostatic Gauze
  - Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, and 4”x4” pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

CONTROLLED SUBSTANCE POLICY

I. PURPOSE

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

II. POLICY

All ICEMA approved ALS providers shall have a formal agreement with a qualified Medical Director or a drug authorizing physician who agrees to purchase controlled substances using the appropriate DEA registration number and forms. This physician will retain ownership, accountability and responsibility for these controlled substances at all times.

All ALS providers shall develop policies compliant with The Controlled Substances Act Title 21, United States Code (USC) and California Code of Regulations Title 22, Division 9, Chapter 4, Article 7, Section 100168. These policies must ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

- Controlled substance ordering and order tracking
- Controlled substance receipt and accountability
- Controlled substance master supply storage, security and documentation
- Controlled substance labeling and tracking
- Vehicle storage and security
- Usage procedures and documentation
- Reverse distribution
- Disposal
- Re-stocking

Additionally, the policies must ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to:

- Controlled substance testing
- Discrepancy reporting

- Tampering, theft and diversion prevention and detection
- Usage audits

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

III. PROCEDURE

All controlled substances shall:

1. Be purchased and stored in tamper evident containers.

2. Be stored in a secure and accountable manner.

3. Be kept under a "double lock" system at all times.

4. Be reconciled at a minimum every 24 hours or at any change of shift or change in personnel.

IV. REQUIRED DOCUMENTATION

1. ALS providers must maintain a log of all purchased controlled substances for a period of no less than two (2) years.

2. All controlled substance usage will be documented on all patient care records (PCR) or electronic patient care reports (ePCR).

3. EMS Provider's medical director must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy.

4. In the event of breakage of a narcotic container an incident report will be completed and the damage reported to the appropriate supervisor.

5. Discrepancies in the narcotic count will be reported immediately to the appropriate supervisor and a written report must be submitted.

SAMPLE DAILY LOG

Agency: _____

Month: _____Year: ___

Double Lock Shift Change Medic Date In Place Midazolam 5mg **On**

	DATE	DOUBLE LOCK IN PLACE?	MIDAZOLAM 5MG	FENTANYL	DRUG ADMINISTERED - AMOUNT GIVEN/WASTED O1A # PATIENT NAME DATE/TIME MEDIC NAME	DUTY MEDIC	CAPTAIN OR SUPERVISOR
1		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
2		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
3		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
4		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
5		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
6		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
7		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature
8		Yes / No	Amount _____	Amount_____		Can Not Be Same Signature	Can Not Be Same Signature

SAMPLE - Master Controlled Substance Inventory Log

Date/Time	Lot Number	Midazolam Quantity	Fentanyl Quantity	Outdated Destroyed	Action Inventory, Restock, Dispensed, Inventory Total	Signatures of Personnel I certify that we have counted and found correct all controlled substances listed.	
						Signature	Signature

MEDICATION - STANDARD ORDERS

Medications listed in this protocol may be used only for the purposes referenced by the associated ICEMA Treatment Protocol. Any other use, route or dose other than those listed, must be ordered in consultation with the Base Hospital physician.

Adenosine (Adenocard) - Adult (ALS)

Stable narrow-complex SVT or Wide complex tachycardia:

Adenosine, 6 mg rapid IVP followed immediately by 20 cc NS bolus, and
Adenosine, 12 mg rapid IVP followed immediately by 20 cc NS bolus if patient does not convert. May repeat one (1) time.

Reference #s 7010, 7020, 11050

Albuterol (Proventil) Aerosolized Solution - Adult (LALS, ALS)

Albuterol, 2.5 mg nebulized, may repeat two (2) times.

Reference #s 6090, 7010, 7020, 11010, 11100

Albuterol (Proventil) Metered-Dose Inhaler (MDI) - Adult (LALS, ALS - Specialty Programs Only)

Albuterol MDI, four (4) puffs every ten (10) minutes for continued shortness of breath and wheezing.

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Albuterol (Proventil) - Pediatric (LALS, ALS)

Albuterol, 2.5 mg nebulized, may repeat two (2) times.

Reference #s 7010, 7020, 14010, 14030, 14070

Albuterol (Proventil) Metered-Dose Inhaler (MDI) - Pediatric (LALS, ALS - Specialty Programs Only)

Albuterol MDI, four (4) puffs every ten (10) minutes for continued shortness of breath and wheezing.

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Aspirin, chewable (LALS, ALS)

Aspirin, 325 mg PO chewed (one (1) adult non-enteric coated aspirin) or four (4) chewable 81 mg aspirin.

Reference #s 2020, 6090, 6110, 7010, 7020, 11060

Atropine (ALS)

Atropine, 0.5 mg IV/IO. May repeat every five (5) minutes up to a maximum of 3 mg or 0.04 mg/kg.

Organophosphate poisoning:
Atropine, 2 mg IV/IO, repeat at 2 mg increments every five (5) minutes if patient remains symptomatic.

Reference #s 6090, 6110, 7010, 7020, 11040, 12020, 13010

Calcium Chloride (ALS)

Calcium Channel Blocker Poisonings:
Calcium Chloride, 1 gm (10 cc of a 10% solution) IV/IO, base hospital order only.

Reference #s 2020, 7010, 7020, 13010

Dextrose - Adult (LALS, ALS)

Dextrose 10% /250 ml (D10W 25 gm) IV/IO Bolus

Reference #s 2020, 6090, 6110, 7010, 7020, 8010, 11050, 11080, 13020, 13030

Dextrose - Pediatric (LALS, ALS)

Hypoglycemia - Neonates (0 - 4 weeks) with blood glucose < 35 mg/dL or pediatric patients (greater than 4 weeks) with glucose < 60 mg/dL:
Dextrose 10%/250 ml (D10W 25 gm) 0.5 gm/kg (5 ml/kg) IV/IO

Reference #s 2020, 7010, 7020, 13020, 13030, 14040, 14050, 14060

Diphenhydramine - Adult (ALS)

Diphenhydramine, 25 mg IV/IO
Diphenhydramine, 50 mg IM

Reference #s 6090, 6110, 7010, 7020, 11010, 13010

Diphenhydramine - Pediatric (ALS)

Diphenhydramine, 1 mg/kg slow IV/IO, not to exceed adult dose of 25 mg, **or**

Diphenhydramine, 2 mg/kg IM not to exceed adult dose of 50 mg IM

Reference #s 7010, 7020, 14030

Dopamine - Adult (ALS)

Dopamine, infusion of 400 mg in 250 ml of NS IV/IO, titrated between 5 - 20 mcg/kg/min to maintain signs of adequate tissue perfusion.

Reference #s 7010, 7020, 8010, 8040, 10140, 11070, 11090, 14080

Dopamine - Pediatric (ALS)

Post resuscitation continued signs of inadequate tissue perfusion:

9 to 14 years	Dopamine, 400 mg in 250 ml of NS to infuse at 5 - 20 mcg/kg/min IV/IO titrated to maintain signs of adequate tissue perfusion.

Reference #s 7010, 7020, 14040

Epinephrine (1:1000) - Adult (LALS, ALS)

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

Epinephrine, 0.3 mg IM

Epinephrine (1:10,000) - Adult (ALS)

For Persistent severe anaphylactic shock:

Epinephrine (1:10,000), 0.1 mg slow IVP/IO. May repeat every five (5) minutes as needed to total dosage of 0.5 mg.

Cardiac Arrest, Asystole, PEA:

Epinephrine, 1 mg IV/IO

Reference #s 2020, 6090, 6110, 7010, 7020, 11010, 11070, 12020

Epinephrine (1:1000) - Pediatric (LALS, ALS)

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Anaphylactic Shock/Severe Allergic Reactions:

Epinephrine, 0.01 mg/kg IM not to exceed adult dosage of 0.3 mg.

Reference #s 2020, 6090, 7010, 7020, 11010, 14010, 14030

Epinephrine (1:10,000) - Pediatric (ALS)

Anaphylactic Shock (no palpable radial pulse and depressed level of consciousness):

Epinephrine (1:10,000), 0.01 mg/kg IV/IO, no more than 0.1 mg per dose. May repeat to a maximum of 0.5 mg.

Cardiac Arrest:

1 day to 8 years	Epinephrine (1:10,000), 0.01 mg/kg IV/IO (do not exceed adult dosage)
9 to 14 years	Epinephrine (1:10,000), 1.0 mg IV/IO

Newborn Care:

Epinephrine (1: 10,000), 0.01mg/kg IV/IO if heart rate is less than 60 after one (1) minute after evaluating airway for hypoxia and assessing body temperature for hypothermia.

Epinephrine (1:10,000), 0.005 mg/kg IV/IO every ten (10) minutes for persistent hypotension as a base hospital order or in radio communication failure.

Post resuscitation continued signs of inadequate tissue perfusion:

1 day to 8 years	Epinephrine (1:10,000), 0.5 mcg/kg/min IV/IO drip

Reference #s 2020, 7010, 7020, 14030, 14040, 14090

Fentanyl - Adult (ALS)

Chest Pain (Presumed Ischemic Origin):

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Isolated Extremity Trauma, Burns:

Fentanyl, 50 mcg slow IV/IO push over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg IV/IO, **or**

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Pacing, synchronized cardioversion:

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat in five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IN. May repeat 50 mcg every ten (10) minutes titrated to pain, not to exceed 200 mcg.

Reference #s 2020, 6090, 6110, 7010, 7020, 7030, 10190, 11060, 11100, 13030, 15010

Fentanyl - Pediatric (ALS)

Fentanyl, 0.5 mcg/kg slow IV/IO over one (1) minute. May repeat in five minutes titrated to pain, not to exceed 100 mcg.

Fentanyl, 1 mcg/kg IM/IN, may repeat every ten (10) minutes titrated to pain not to exceed 200 mcg.

Reference #s 2020, 6110, 7010, 7020, 7030, 11060, 13030, 14070, 15020

Glucose - Oral - Adult (BLS, LALS, ALS)

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 11080, 11090, 11110, 13020

Glucose - Oral - Pediatric (BLS, LALS, ALS)

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 14050, 14060

Glucagon - Adult (LALS, ALS)

Glucagon, 1 mg IM/SC/IN, if unable to establish IV. May administer one (1) time only.

Betablocker Poisoning:
Glucagon, 1 mg IV/IO (base hospital order only)

Reference #s 6090, 6110, 7010, 7020, 11080, 13010, 13030

Glucagon - Pediatric (LALS, ALS)

Glucagon, 0.025 mg/kg IM/IN, if unable to start an IV. May be repeated one (1) time after twenty (20) minutes for a combined maximum dose of 1 mg.

Reference #s 7010, 7020, 13030, 14050, 14060

Ipratropium Bromide (Atrovent) Inhalation Solution use with Albuterol Adult (ALS)

Atrovent, 0.5 mg nebulized. Administer one (1) dose only.

Reference #s 7010, 7020, 11010, 11100

Ipratropium Bromide (Atrovent) Metered-Dose Inhaler (MDI) use with Albuterol Adult (ALS - Specialty Programs Only)

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 11010, 11100

Ipratropium Bromide (Atrovent) Inhalation Solution use with Albuterol - Pediatric (ALS)

1 day to 12 months	Atrovent, 0.25 mg nebulized. Administer one (1) dose only.
1 year to 14 years	Atrovent, 0.5 mg nebulized. Administer one (1) dose only.

Reference #s 7010, 7020, 14010, 14030, 14070

Ipratropium Bromide (Atrovent) Metered-Dose Inhaler (MDI) use with Albuterol - Pediatric (ALS - Specialty Programs Only)

When used in combination with Albuterol MDI use Albuterol MDI dosing.

Reference #s 6090, 6110, 7010, 7020, 14010, 14030, 14070

Lidocaine - Adult (ALS)

Intubation, King Airway, NG/OG, for suspected increased intracranial pressure (ICP):
Lidocaine, 1.5 mg/kg IV/IO

VT/VF:
Initial Dose: Lidocaine, 1.5 mg/kg IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF.

VT/VF Infusion:
Lidocaine, 2 mg/min IV/IO drip

V-Tach, Wide Complex Tachycardia – with Pulses:
Lidocaine, 1.5 mg/kg slow IV/IO

May administer an additional 0.75 mg/kg IV/IO, repeat once in five (5) to ten (10) minutes for refractory VF

Initiate infusion of Lidocaine 2 mg/min IV/IO drip.

Reference #s 2020, 6090, 7010, 7020, 8010, 8040, 10030, 10080, 10190, 11050, 11070, 15010

Lidocaine - Pediatric (ALS)

King Airway, NG/OG, for suspected increased intracranial pressure (ICP):
Lidocaine, 1.5 mg/kg IV/IO

Cardiac Arrest:

1 day to 8 years	Lidocaine, 1.0 mg/kg IV/IO
9 to 14 years	Lidocaine, 1.0 mg/kg IV/IO

May repeat Lidocaine at 0.5 mg/kg after five (5) minutes up to total of 3.0 mg/kg.

Reference #s 2020, 7010, 7020, 14040

Lidocaine 2% (Intravenous Solution) - Pediatric and Adult (ALS)

Pain associated with IO infusion:
Lidocaine, 0.5 mg/kg slow IO push over two (2) minutes, not to exceed 40 mg total.

Reference #s 2020, 7010, 7020, 10140, 10190

Magnesium Sulfate (ALS)

Polymorphic Ventricular Tachycardia:
Magnesium Sulfate, 2 gm IV/IO bolus over five (5) minutes for polymorphic VT if prolonged QT is observed during sinus rhythm post-cardioversion.

Eclampsia (Seizure/Tonic/Clonic Activity):
Magnesium Sulfate, 4 gm IV/IO slow IV push over three (3) to four (4) minutes.

Magnesium Sulfate, 10 mg/min IV/IO drip to prevent continued seizures.

Reference #s 2020, 7010, 7020, 8010, 14080

Midazolam (Versed) - Adult (ALS)

Seizure:
Midazolam, 2.5 mg IV/IO/IN. May repeat in five (5) minutes for continued seizure activity, **or**

Midazolam, 5 mg IM. May repeat in ten (10) minutes for continued seizure activity.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Pacing, synchronized cardioversion:

Midazolam, 2 mg slow IV/IO push or IN

Reference #s 6090, 6110, 7010, 7020, 10110, 10120, 10190, 11080, 13020, 14080

Midazolam (Versed) - Pediatric (ALS)

Seizures:

Midazolam, 0.1 mg/kg IV/IO with maximum dose 2.5 mg. May repeat Midazolam in five (5) minutes, **or**

Midazolam, 0.2 mg/kg IM/IN with maximum dose of 5 mg. May repeat Midazolam in ten (10) minutes for continued seizure. IN dosage of Midazolam is doubled due to decreased surface area of nasal mucosa resulting in decreased absorption of medication.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 7010, 7020, 14060

Naloxone (Narcan) - Adult (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

Naloxone, 0.5 mg IV/IO/IM/IN, may repeat Naloxone 0.5 mg IV/IO/IM/IN every two (2) to three (3) minutes if needed.

Do not exceed 10 mg of Naloxone total regardless of route administered.

Reference #s 6110, 7010, 7020, 11080

Naloxone (Narcan) - Pediatric (LALS, ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

1 day to 8 years	Naloxone, 0.1 mg/kg IV/IO/IM/IN
9 to 14 years	Naloxone, 0.5 mg IV/IO/IM/IN

May repeat every two (2) to three (3) minutes if needed. Do not exceed the adult dosage of 10 mg IV/IO/IM/IN.

Reference #s 7010, 7020, 14040, 14050

Nitroglycerin (LALS, ALS)

Nitroglycerin, 0.4 mg sublingual/transmucosal

One (1) every three (3) minutes as needed. May be repeated as long as patient continues to have signs of adequate tissue perfusion. **If a Right Ventricular Infarction is suspected, the use of nitrates requires base hospital contact.**

Nitroglycerin is contraindicated if there are signs of inadequate tissue perfusion or if sexual enhancement medications have been utilized within the past forty-eight (48) hours.

Reference #s 6090, 6110, 7010, 7020, 11010, 11060

Ondansetron (Zofran) - Patients four (4) years old to Adult (ALS)

Nausea/Vomiting:

Ondansetron, 4 mg slow IV/IO/ODT

All patients four (4) to eight (8) years old: May administer a total of 4 mgs of Ondansetron prior to base hospital contact.

All patients nine (9) and older: May administer Ondansetron 4 mg and may repeat twice, at ten (10) minute intervals, for a total of 12 mgs prior to base hospital contact.

May be used as prophylactic treatment of nausea and vomiting associated with narcotic administration.

Reference #s 6110, 7010, 7020, 9120, 10100, 15010, 15020

Oxygen (non-intubated patient per appropriate delivery device)

General Administration (Hypoxia):

Titrate Oxygen at lowest rate required to maintain SPO_2 at 94%.
Do not administer supplemental oxygen for $SPO_2 > 95\%$

Chronic Obstructive Pulmonary Disease (COPD):

Titrate Oxygen at lowest rate required to maintain SPO_2 at 90%
Do not administer supplemental oxygen for $SPO_2 > 91\%$

Reference #s 6140, 9010, 9120, 11010, 11020, 11040, 11050, 11060, 11080, 11090, 11100, 13010, 13020, 13030, 14010, 14020, 14030, 14050, 14060, 14070, 14080, 14090, 15010, 15020

Phenylephrine HCL (ALS)

Phenylephrine, 0.5 mg metered dose may be repeated once prior to additional attempt

Reference #s 7010, 7020, 10050, 10190

Sodium Bicarbonate (ALS) (base hospital order only)

Tricyclic Poisoning:
Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #s 2020, 7010, 7020, 13010

INTERFACILITY TRANSFER GUIDELINES

I. PURPOSE

To identify patient care responsibilities for emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics (EMT-Ps) during interfacility transports.

II. BLS INTERVENTIONS

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

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

- Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
  - No medications have been added to the IV fluid.
  - Maintain the IV at a pre-set rate.
  - Check tubing for kinks and reposition arm if necessary.
  - Turn off IV fluid if signs/symptoms of infiltration occur.
  - Control any bleeding at insertion site.
- Transport a patient with a urinary catheter provided the following:
  - The catheter is able to drain freely.
  - No action is taken to impede flow or contents of drainage collection bag.
- Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped.
- If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

III. LIMITED ALS (LALS) INTERVENTIONS

During an interfacility transport, if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via LALS ambulance, an AEMT may monitor or perform the following:

- Peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Saline locks.
- Tracheo-bronchial suction of an intubated patient.
- Initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

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

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

AEMTs may not transport patients with blood or blood products.

IV. ALS INTERVENTIONS

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

If the transfer is a STEMI patient, refer to ICEMA Reference#8040 - Continuation of Care of a STEMI Patient (San Bernardino Only).

EMT-Ps may not transport a patient with IV drips that are not in the EMT-P scope of practice.

EMT-Ps may not transport patients with blood or blood products.

During an interfacility transport, an ICEMA accredited EMT-P may:

- Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.

- Transport intravenous solutions with added medication(s) as follows:
  - Lidocaine
  - Dopamine
  - Magnesium Sulfate
- Monitor and administer medications through a pre-existing vascular access.
- Monitor heparin lock or saline lock.
- Monitor IV solutions containing potassium ≤40mEq/L.
- Monitor thoracostomy tubes to water or dry sealed drainage.
- Monitor nasogastric tubes.
- EMT-Ps may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station per ICEMA Reference #5040 - Radio Communication Policy.

V. NURSE ASSISTED ALS TRANSPORT

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

VI. REFERENCES

Number	Name
5040	Radio Communication Policy
8040	Continuation of Care of a STEMI Patient (San Bernardino Only)

SPECIALTY CARE TRANSPORT

I. PURPOSE

To establish the criteria for the approval of Specialty Care Transport (SCT) providers and personnel operating within San Bernardino, Inyo or Mono Counties.

II. PROGRAM APPROVAL

1. Requests for approval must be made in writing 60 days prior to the anticipated starting date of service. The request must include:

    a. Proposed identification, location of the SCT unit, and geographic coverage area.

    b. Proposed SCT staffing, including Registered Nurse (RN) or Respiratory Care Practitioner (RCP) and a Paramedic (EMT-P) or Emergency Medical Technician (EMT).

    c. A description of the procedures to be followed for changes in destination due to unforeseen changes in the patient's condition or other unexpected circumstances.

    d. A copy of all policies, protocols and procedures that are approved by the SCT provider's Medical Director.

    e. A description of the orientation program and process utilized to verify skill competency for SCT personnel.

    f. Documentation identifying and listing the qualifications for the SCT provider's Medical Director, including current license, certifications and resume/curriculum vitae.

    g. Documentation identifying and listing the qualifications for the SCT Nurse Coordinator, including current license, certifications, and resume/curriculum vitae.

    h. A quality improvement (QI) plan, or an amendment to the EMS provider's QI Plan, that describes the QI process for interfacility SCT. The plan must comply with all provisions of the ICEMA QI Plan and include 100% review of all patient care reports in which SCT is utilized.

i. Agreement to comply with all ICEMA policies and protocols for transport of critical injured or ill patients and quality improvement.

2. ICEMA will notify the applicant in a timely manner, if any further documentation is needed.

3. The applicant will be notified in writing of approval or denial of the program within 60 days.

III. POLICY

1. A private ambulance company must be ICEMA approved to operate in San Bernardino, Inyo, or Mono Counties as a Basic Life Support (BLS) or Advanced Life Support (ALS) provider.

2. A private ambulance provider must be ICEMA approved to employ RNs and/or RCPs to staff and provide SCT.

3. All EMS providers interested in providing SCT utilizing any combination of RNs and/or RCPs and EMT-Ps or EMTs shall provide the information required for program approval for review to determine eligibility.

4. This policy does not apply when RNs or RCPs, employed by a healthcare facility, are occasionally utilized by an EMS transport provider to provide interfacility patient transport as part of emergent situations.

IV. DOCUMENTATION FOR SCT

- An ICEMA approved electronic patient care report (ePCR) is required for all transported patients.

- If a paper downtime form is utilized, EMS providers are required to submit an ICEMA approved ePCR by the end of shift or within 24 hours of the transport (whichever is less).

- The EMS provider shall conduct a 100% review of all patient care reports as part of their QI program.

V. EQUIPMENT

The EMS provider shall provide the following equipment:

1. BLS equipment per ICEMA Reference #7010 - BLS/LALS/ALS Standard Drug & Equipment List.

2. ALS equipment per ICEMA Reference #7010 - BLS/LALS/ALS Standard Drug and Equipment List when utilizing a RN or EMT-P.

3. Additional equipment as needed to provide required specialized treatment and care.

VI. SCT MEDICAL DIRECTOR

1. A full or part-time physician licensed in the State of California and qualified by training and experience with practice, within the last five (5) years, in emergency or acute critical care medicine. The ICEMA Medical Director must approve the candidate for medical director.

2. The duties of the SCT medical director shall include but not be limited to:

   - Sign and approve, in advance, all medical protocols to be followed by the RN and/or RCP.

   - Ensure the ongoing training of SCT personnel in SCT provider's policies and treatment protocols relative to their level of care and scope of practice.

   - Be familiar with the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

   - Ensure the ongoing training of staff in EMTALA and HIPAA requirements.

   - Participate in the development, implementation, and ongoing evaluation of the QI program to ensure the quality of patient care and safe transport of patients.

VII. SCT NURSE COORDINATOR

1. A full or part-time RN, licensed in the State of California that is qualified by training and/or experience in emergency or acute critical care medicine, within the last five (5) years, in emergency or acute critical care nursing. The duties of the SCT Nurse Coordinator shall include but not be limited to:

   - Maintain documentation indicating that all SCT personnel have been properly oriented to the SCT program.

   - Maintain documentation for all applicable licensure, certification and/or accreditation requirements of all SCT personnel.

   - Provide ongoing training to all SCT personnel.

- Be familiar with EMTALA and HIPAA requirements.
- Provide ongoing training of staff in EMTALA and HIPAA requirements.
- Ensure the development, implementation and ongoing evaluation of the SCT provider's QI program in collaboration with the SCT Medical Director.

VIII. SCT PERSONNEL

1. SCT personnel shall:

   - Be utilized to perform duties within their respective scope of practice but must be accompanied by other medical personnel, when required, based on patient acuity and/or anticipated patient care requirements.
   - Be currently licensed or certified for unrestricted practice in California.
   - Currently possess a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent.
   - Currently possess a valid American Heart Association Advanced Cardiac Life Support (ACLS) card (except EMTs). ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

2. SCT personnel shall be credentialed per the following ICEMA policies:

   - RNs shall be authorized as a Mobile Intensive Care Nurse (MICN) per ICEMA Reference #1050 - MICN Authorization - Base Hospital, Administrative, Flight Nurse and Critical Care Transport.
   - RCPs shall be authorized by ICEMA per ICEMA Reference #1110 - RCP Authorization.
   - EMT-Ps utilized as part of a SCT shall be accredited per ICEMA Reference #1040 - EMT-P Accreditation.
   - EMTs utilized as part of a SCT shall be certified per ICEMA Reference #1030 - EMT Certification.

IX. PROCEDURES

1. Each SCT provider shall develop and maintain procedures for the hiring and training of SCT personnel.

2. Each SCTs provider must develop a manual to include the following:

   - Malpractice insurance coverage.
   - Identity and accessibility of the SCT Medical Director and SCT Nurse Coordinator.
   - Vehicle inventory lists including minimum equipment listed in equipment above.
   - Copies of all related interfacility transfer paperwork and instruction for completing the ePCR.
   - Guidelines for change in patient destination due to patient condition and procedures for base hospital contact when necessary.
   - Any protocols (standing orders) to be followed by the RN and/or RCP based on ACLS, PALS and/or NALS guidelines and approved by the SCT Medical Director.
   - Any medical protocols to be followed by the RN and/or RCP and approved by the SCT Medical Director

3. All policies and protocols are subject to review by ICEMA.

X. REFERENCES

Number	Name
1030	EMT Certification
1040	EMT-P Accreditation
1050	MICN Authorization - Base Hospital, Administrative, Flight Nurse and Critical Care Transport
1110	RCP Authorization
7010	BLS/LALS/ALS Standard Drug & Equipment List

TRANSPORT OF PATIENTS (BLS)

In the prehospital setting or during interfacility transport, a certified EMT-I or supervised EMT-I trainee who has received appropriate training may monitor peripheral lines delivering intravenous fluids, Foley catheters, heparin locks, nasogastric tubes and gastrostomy tubes under Section 10015(b), Title 22 of the California Health and Safety Code provided the following conditions are met:

1. An EMT-I may monitor peripheral lines delivering intravenous fluids during interfacility transport and in the prehospital setting with the following restrictions:

    a. Interfacility transfers: The patient is not critical and deemed stable by the transferring physician and that physician authorizes transport.

    b. Scene transport: The patient is not critical and the base station physician approves transport by an EMT-I.

    c. No medications have been added to the intravenous fluids.

    d. In the prehospital setting, no other advanced life support procedures have been initiated.

2. The EMT-I shall:

    a. Monitor and maintain the IV at a preset rate.

    b. Check the tubing for kinks and reposition the arm if necessary when loss of flow occurs.

    c. Control the bleeding at the IV site.

    d. Turn off the flow of intravenous fluid if infiltration or alteration of flow occurs. Vital signs should then be monitored frequently.

    e. Transfer patient with any combination/concentration of:

        i. D5/water with or without:

            1.) Normal Saline

            2.) Lactated Ringers

3.) Isolyte or Isolyte M

ii. Normal Saline

iii. Lactated Ringers

3. An EMT-I may transport a patient with a heparin lock provided:

   a. The patient is not critical and deemed stable by the transferring Physician or Base Station physician and the transferring physician approves transport by an EMT-I.

   b. The EMT-I shall:

      i. Monitor the heparin lock only as placed at time of transfer.

      ii. Control any bleeding at insertion site.

4. An EMT-I may transport a patient with a Foley catheter provided:

   a. The patient is noncritical and deemed stable by the transferring Physician or Base station Physician and the transferring physician approves transport by an EMT-I.

   b. The catheter is able to drain freely to gravity.

   c. No action is taken to impede flow or disrupt contents of drainage collection bag.

5. An EMT-I may transport a patient with a nasogastric tube or gastrostomy tube provided:

   a. The patient is not critical and deemed stable by the transferring Physician or Base Station Physician and the physician approves transport by an EMT-I.

   b. Nasogastric and gastrostomy tubes are clamped.

   c. All patients who have received fluids prior to transport are transferred in semi-fowlers position to prevent aspiration unless contraindicated.

6. If at any time the patient’s condition deteriorates, the patient should be transported to the closest Receiving Hospital.

REQUESTS FOR HOSPITAL DIVERSION POLICY

(San Bernardino County Only)

PURPOSE

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

AUTHORITY

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

PRINCIPLES

1. A request for diversion of ALS ambulances should be a temporary measure.

2. Final authority relating to destination of ALS ambulances rests with the Base Station physician.

3. This policy applies to the 9-1-1 emergency system and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.

4. A hospital's request to divert in the approved categories shall be made by the Emergency Department (ED) attending physician or by the trauma surgeon for trauma hospital diversion, in consultation with the hospital CEO or delegated responsible administrative representative. The consultation with the administrative officer must be documented and available for review.

5. Hospitals must maintain a hospital diversion policy that conforms to the ICEMA's Request for Hospital Diversion Policy. The policy should include plans to educate all appropriate staff on proper utilization of diversion categories, internal procedures for authorizing diversion and procedures for notification of system participants.

6. ICEMA may perform unannounced site visits to hospitals on temporary diversion status to ensure compliance with the ICEMA Request for Hospital Diversion Policy.

7. ICEMA may randomly audit Base Station records to ensure diverted patients are transported to the appropriate destination.

8. When possible, ICEMA staff will contact the hospital to determine the reasons for Internal Disaster Diversion, under Policy, Item #3.

9. ICEMA reserves the right and responsibility to advise any hospital that the diversion is not appropriate for a 9-1-1 system and may remove the hospital from diversion through the ReddiNet System.

POLICY

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

1. **Neuro/CT Diversion**

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

      1) New onset of altered level of consciousness for traumatic or medical reasons. ** Does not apply to trauma centers for trauma diversion. Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.

      2) Suspected stroke. ** Does not apply to neurovascular stroke receiving centers. Refer to ICEMA Reference #6100 - Stroke "NSRC" Receiving Centers.

2. **Trauma Center Diversion (*for use by designated Trauma Centers only*)**

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

   b. The request for Trauma Center Diversion should only be applicable if the general surgeon and back-up general surgeon are committed. The ability to request Trauma Center Diversion cannot be used in cases of temporary unavailability of subspecialists.

   c. **When all designated trauma centers are on Trauma Center Diversion, trauma centers shall accept all trauma patients.**

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

3. **Internal Disaster Diversion**

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

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

      Internal Disaster Diversion shall not be used for staffing issues.

   b. Internal Disaster Diversion shall stop all 9-1-1 transports into the facility.

   c. The hospital CEO or AOD shall be notified and that notification shall be documented in the ReddiNet.

   d. If the hospital is also a designated Base Station, the hospital should consider immediately transfer of responsibility for on-line control to another Base Station based upon prearranged written agreement and notification to the 9-1-1 provider.

   e. Internal Disaster Diversion status shall be entered immediately into the ReddiNet System.

   f. If capability exists, hospital shall notify all primary 9-1-1 dispatching agencies.

   g. Within seventy-two (72) hours, hospital shall advise ICEMA and the State Department of Health Services in writing (e-mail is acceptable) of the reasons for internal disaster and how the problem was corrected. The written notification shall be signed by the CEO or delegated responsible individual.

EXCEPTIONS TO NEURO/CT AND TRAUMA DIVERSION ONLY

1. Basic life support (BLS) ambulances shall not be diverted.

2. Ambulances on hospital property shall not be diverted.

3. Patients exhibiting unmanageable problems, e.g., unmanageable airway, uncontrolled hemorrhage, cardiopulmonary arrest, in the field shall be transported to the closest Emergency Department regardless of diversion status.

REFERENCES

Number	**Name**
6100	Stroke "NSRC" Receiving Centers
15030	Trauma Triage Criteria and Destination Policy

AIRCRAFT ROTATION POLICY

(San Bernardino County Only)

PURPOSE

To establish EMS Aircraft dispatch rotation criteria for San Bernardino County Communication Center (COMM Center).

AUTHORITY

California Health and Safety Code Division 2.5, Chapter 4 and 5; California Code of Regulations.

POLICY

1. All EMS Aircraft requests from the field in San Bernardino County will be dispatched by the San Bernardino County COMM Center.

2. At time of dispatch, COMM Center will inform the EMS Aircraft of destination based on the following:

    a. Destination will alternate between ARMC and LLUMC as determined by ICEMA.

    b. The destination may be changed by the EMS providers based on patient requirements for specialty centers.

    c. Cancellation or destination change of an EMS Aircraft will not alter the rotation of dispatched aircraft.

    d. Approved Diversion will alter the rotation of EMS aircraft (ICEMA Reference #8060 - San Bernardino County Requests for Hospital Diversion Policy.)

3. An EMS Aircraft going to a destination other than the one assigned by Comm Center, will notify COMM Center and the receiving facility. Notification maybe made by ground or air crews, whichever is the most expeditious for information to be given to the receiving facility.

4. Changes to EMS Aircraft rotation may be reviewed for potential QI issues.

FORT IRWIN CONTINUATION OF CARE

THIS POLICY IS FOR FORT IRWIN FIRE DEPARTMENT (FIFD), FORT IRWIN DEPARTMENT OF EMERGENCY SERVICES (DES), FORT IRWIN ARMY AIR AMBULANCE AND WEED ARMY COMMUNITY HOSPITAL (WACH) FOR TRANSPORTATION AND TRANSFER OF STEMI, STROKE OR TRAUMA PATIENTS TO A TRAUMA CENTER OR SPECIALTY CARE CENTER ONLY AND SHALL NOT BE USED FOR ANY OTHER TRANSFERS OR REQUESTS FOR TRANSFER FROM OTHER FACILITIES.

I. PURPOSE

To provide a mechanism of rapid transport of STEMI, stroke, or trauma patients from within the boundaries of Fort Irwin and the National Training Center to an appropriate STEMI, stroke, or trauma center for higher level of care with minimal delay. The terrain and nature of the National Training Center at Fort Irwin presents particular obstacles for the transport of STEMI, stroke, or trauma patients. Most STEMI, stroke, or trauma patients must be airlifted to an appropriate Specialty Care Center.

II. POLICY

1. Weed Army Community Hospital (WACH) to a STEMI Receiving Center (SRC), Neurovascular Stroke Center (NRSC) or Trauma Center (TC).

   a. PATIENT INCLUSION CRITERIA

   - Any patient meeting ICEMA Trauma Triage Criteria, (refer to ICEMA Reference #15030 - Trauma Triage Criteria and #8130 - Destination Policy) arriving at a non-trauma hospital by EMS or non-EMS transport.

   - Any patient with a positive STEMI requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy).

   - Any patient with a positive mLAPSS or stroke scale requiring EMS transport to a NSRC (refer to ICEMA Reference #6100 - Neurovascular Stroke Receiving Centers Destination Policy).

- These procedures are not to be used for any other form of interfacility transfer of patients.

b. INITIAL TREATMENT GOAL AT WACH

- Initiate resuscitative measures within the capabilities of the hospital.

- Ensure patient stabilization is adequate for subsequent transport.

- DO NOT DELAY TRANSPORT by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

- WACH ED physician will determine the appropriate mode of transportation for the patient. WACH will contact Fort Irwin Army MEDEVAC for air ambulance transport utilizing established procedures for Fort Irwin.

- GUIDELINES:

  < 30 minutes at WACH (door-in/door-out).
  < 45 minutes to complete continuation of care transport.
  < 30 minutes door-to-intervention at Specialty Care Center.

- WACH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. WACH will contact the assigned Specialty Care Center in accordance with ICEMA Policy #8120 - Continuation of Care (San Bernardino County Only).

  SRC: Desert Valley Hospital, St. Mary Medical Center
  NSRC: Loma Linda University Medical Center, Arrowhead Regional Medical Center
  TC: Loma Linda University Medical Center, Arrowhead Regional Medical Center

- WACH ED physician will provide a verbal report to the ED physician at the Specialty Care Center.

- Fort Irwin Army MEDEVAC will make Specialty Care Center base hospital contact.

- Specialty Care Centers shall accept all referred STEMI, stroke, or trauma patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).

- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal STEMI, Stroke, or Trauma Team according to internal SRC, NSRC or TC policies or protocols.

  WACH must send all medical records, test results and radiologic evaluations to the Specialty Care Center. DO NOT DELAY TRANSPORT - these documents may be FAXED to the Specialty Care Center.

c. SPECIAL CONSIDERATIONS

- If a suspected stroke patient is outside of the tPA administration window (greater than 4.5 hours from "last seen normal"), contact nearest NSRC to determine the best destination.

- ICEMA EMT-Ps may only transport patients on Dopamine and Lidocaine drips. Heparin and Integrillin drips are not within the ICEMA EMT-P scope of practice.

- WACH should consider sending one of its nurses, or a physician, with the Fort Irwin Army MEDEVAC if deemed necessary due to the patient's condition or scope of practice. This practice is highly encouraged. US Army Flight Medics and Critical Care Flight Paramedics may request additional providers from WACH upon its assessment of the patient's condition and en route care needs.

- Specialty Care Center diversion is not permitted except for Internal Disaster. However, Specialty Care Center base hospitals are allowed to facilitate redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to minimize door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

2. AIR AMBULANCE

a. Fort Irwin maintains internal 24-hour US Army Air Ambulance with MEDEVAC capabilities conducted by C Company (Air Ambulance), 2916th Aviation Battalion. Fort Irwin Army Air Ambulance is the primary method of air transport for medical and trauma patients originating within the boundaries of the National Training Center and Fort Irwin. Requests for use of this asset by Fort Irwin Range Control, DES, FIFD and WACH will be in accordance with the procedures established within Fort Irwin. To expedite appropriate treatment of STEMI, stroke, or trauma patients, Fort Irwin Army Air Ambulance will proceed directly to the most appropriate SRC, NSRC or TC, for patients that meet the criteria of ICEMA Reference #15030 - Trauma Triage Criteria, #8120 - Continuation of Care and #8130 - Destination Policy when immediate lifesaving intervention or stabilization is <u>not</u> required. These patients will bypass WACH and proceed directly to a SRC, NSRC or TC for treatment.

b. Fort Irwin Army Air Ambulance will contact the County Communication Center (CCC) for TC destination. TC destination will be rotated by the CCC in accordance with ICEMA Reference #8070 - Aircraft Rotation Policy (San Bernardino County Only). If unable to contact the CCC, Fort Irwin Army MEDEVAC will follow the destination policy established in ICEMA Reference #8130 - Destination Policy.

c. The assigned base hospital for medical control will be Loma Linda University Medical Center (LLUMC). ICEMA EMT-Ps will follow ICEMA's policies, procedures and protocols. US Army Flight Medics and Critical Care Flight Paramedics will follow the Standard Medical Operating Guidelines (SMOG) established by the US Army Surgeon General and the assigned US Army Flight Surgeon. When conflicts in procedure or protocol of patient care exists between ICEMA and the US Army SMOG, each EMS provider will work in accordance with its individual protocols and confer jointly to assure the best possible care is provided and achieves the best outcome for the patient. US Army Flight Medics and Critical Care Flight Paramedics are authorized to perform all treatments and procedures that are provided as en route medical orders from the receiving hospital or the medical direction of LLUMC.

d. The onboard attending FIFD ICEMA EMT-P will make contact with the destination SRC, NSRC or TC prior to arrival in order to alert the STEMI, Stroke, or Trauma Teams. In the absence of the FIFD ICEMA EMT-P, the US Army Flight Medic or US Army Critical Care Flight Paramedic will ensure contact is made in accordance with Fort Irwin's procedures.

e. In the event of special considerations, such as weather, time, distance and patient location, the Fort Irwin Army Air Ambulance Pilot-in-Command may choose to divert to University Medical Center (UMC) Las Vegas in accordance with the Memorandum of Agreement established between Fort Irwin Army Air Ambulance and UMC Las Vegas.

f. In times of inclement weather or due to aircraft emergencies where landing at the destination hospital is not feasible, Fort Irwin MEDEVAC will contact the CCC for assistance in order to arrange for ground ambulance transportation at an appropriate airfield or the precautionary landing zone so that transportation of the patient can continue to the designated hospital.

g. Should Fort Irwin Army Air Ambulance be unavailable for patient transportation, requests for civilian air ambulance support shall be made through the CCC by FIFD or WACH.

3. GROUND AMBULANCE

a. Ground ambulances on Fort Irwin are provided and staffed by WACH and are dispatched by Fort Irwin DES with support from FIFD.

b. Patients that are determined to meet ICEMA's Trauma Triage Criteria (refer to ICEMA Reference #15030 - Trauma Triage Criteria) or are in immediate need of a Specialty Care Center as determined by a FIFD ICEMA EMT-P may be transported directly to the Fort Irwin Main Post Helipad or designated ambulance exchange point for immediate transfer by air ambulance when immediate lifesaving intervention or stabilization is <u>not</u> required. These patients will bypass WACH and proceed directly to a SRC, NSRC or TC for treatment. Coordination for this exchange will be conducted by FIFD utilizing established procedures to contact Fort Irwin Army MEDEVAC.

c. Patients that do not meet ICEMA's Trauma Triage Criteria or require immediate lifesaving interventions or stabilization will be transported directly to WACH.

III. REFERENCES

Number	Name
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy
6100	Neurovascular Stroke Receiving Centers Destination Policy (San Bernardino County Only)
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)
8070	Aircraft Rotation Policy (San Bernardino County Only)
8120	Continuation of Care (San Bernardino County Only)
8130	Destination Policy
15030	Trauma Triage Criteria

CONTINUATION OF CARE

(San Bernardino County Only)

I. PURPOSE

To develop a system that ensures the rapid transport of patients at the time of symptom onset or injury, to receiving the most appropriate definitive care. This system of care consists of public safety answering point (PSAP) providers, EMS providers, referral hospitals (RH), Specialty Care Centers (Trauma, Cardiovascular ST Elevation Myocardial Infarction (STEMI) or Stroke), ICEMA and EMS leaders combining their efforts to achieve this goal.

This policy shall only be used for:

- Rapid transport of trauma, STEMI and stroke patients from RH to Specialty Care Center.
- Specialty Care Center to Specialty Care Center when higher level of care is required.
- EMS providers transporting unstable patients requiring transport to a Specialty Care Center to stop at any closest receiving hospital for airway stabilization, and continue on to a Specialty Care Center.

It is <u>not</u> to be used for any other form of interfacility transfer of patients.

II. DEFINITIONS

Neurovascular Stroke Receiving Centers (NSRC): A licensed general acute care hospital designated by ICEMA's Governing Board as a NSRC.

Referral Hospital (RH): Any licensed general acute care hospital that is not an ICEMA designated TC, SRC or NSRC.

Specialty Care Center: An ICEMA designated Trauma, STEMI or Stroke Center.

STEMI Receiving Centers (SRC): A licensed general acute care hospital designated by ICEMA's Governing Board as STEMI Receiving Center with emergency interventional cardiac catheterization capabilities.

Trauma Center (TC): A licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws, regulations and ICEMA policies.

III. INCLUSION CRITERIA

- Any patient meeting ICEMA Trauma Triage Criteria, (refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy) arriving at a non-trauma hospital by EMS or non-EMS transport.

- Any patient with a positive STEMI requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and Destination Policy).

- Any patient with a positive mLAPSS or stroke scale requiring EMS transport to a NSRC (refer to ICEMA Reference #6100 - Neurovascular Stroke Receiving Centers Criteria and Destination Policy).

IV. INITIAL TREATMENT GOALS AT RH

- Initiate resuscitative measures within the capabilities of the facility.

- Ensure patient stabilization is adequate for subsequent transport.

- <u>Do not delay transport</u> by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

  - GUIDELINES

    < 30 minutes at RH (door-in/door-out).
    < 30 minutes to complete ALS continuation of care transport.
    < 30 minutes door-to-intervention at Specialty Care Center.

- RH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. Refer to Section IV - SRH-SRC Buddy System Table.

- EMS providers shall make Specialty Care Center base hospital contact.

- The Specialty Care Centers shall accept all referred trauma, stroke and STEMI patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).

- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal Trauma, STEMI, or Stroke Team according to internal TC, SRC or NSRC policies or protocols.

- RH ED physician will determine the appropriate mode of transportation for the patient.

- Simultaneously call 9-1-1 and utilize the following script to dispatch:

  "This is a Continuation of Care run from ____hospital to ____Trauma, STEMI or Stroke Center"

  Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

- RH ED physician will provide a verbal report to the ED physician at the Specialty Care Center.

- RH must send all medical records, test results, radiologic evaluations to the Specialty Care Center. DO NOT DELAY TRANSPORT - these documents may be FAXED to the Specialty Care Center.

V. SPECIAL CONSIDERATIONS

- If the patient has arrived at the RH via EMS field personnel, the RH ED physician may request that the transporting team remain and immediately transport the patient once minimal stabilization is done at the RH.

- If a suspected stroke patient is outside of the tPA administration window (greater than 4.5 hours from "last seen normal"), contact nearest stroke center to determine the best destination. Then follow the 9-1-1 script.

- EMT-Ps may only transport patients on Dopamine and Lidocaine drips. Heparin and Integrillin drips are not within the EMT-P scope of practice and require a critical care transport nurse to be in attendance. Unless medically necessary, avoid using medication drips that are outside of the EMT-P scope of practice to avoid any delays in transferring of patients.

- The RH may consider sending one of its nurses or physician with the transporting ALS unit if deemed necessary due to the patient's condition or scope of practice.

- Requests for Specialty Care Transport (SCT) (ground or air ambulance) must be made directly with the EMS provider's dispatch center. The request for SCT should be made as early as possible or simultaneously upon patient's arrival so availability of resource can be determined.

- Specialty Care Center diversion is not permitted except for Internal Disaster. However, Specialty Care Center base hospitals are allowed to facilitate redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to avoid prolonged door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

VI. SPECIALTY CARE CENTER - REFERRAL HOSPITAL BUDDY SYSTEM TABLE

NEUROVASCULAR STROKE RECEIVING CENTERS (NSRC)	NEUROVASCULAR STROKE REFERRAL HOSPITALS (NSRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Colorado River Medical Center • Community Hospital of San Bernardino • Hi Desert Medical Center • St. Bernardine Medical Center • St. Mary Medical Center
Desert Regional Medical Center	• Colorado River Medical Center • Hi-Desert Medical Center
Kaiser Hospital Foundation - Fontana	• Barstow Community Hospital • Victor Valley Global Medical Center • Desert Valley Hospital
Kaiser Hospital Foundation - Ontario	• Chino Valley Medical Center • Montclair Community Hospital
Loma Linda University Medical Center	• Bear Valley Community Hospital • Community Hospital of San Bernardino • J.L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital • St. Bernardine Medical Center • Weed Army Community Hospital at Fort Irwin
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
Redlands Community Hospital	• Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Mountains Community Hospital
San Antonio Regional Hospital	• Chino Valley Medical Center • Desert Valley Hospital • Montclair Hospital Medical Center • St. Mary Medical Center • Victor Valley Global Medical Center

STEMI RECEIVING CENTER (SRC)	STEMI REFERRAL HOSPITAL (SRH)
Desert Valley Hospital	• Barstow Community Hospital • Victor Valley Global Medical Center • Weed Army Community Hospital at Fort Irwin
Loma Linda University Medical Center	• Arrowhead Regional Medical Center • Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Redlands Community Hospital
Pomona Valley Hospital Medical Center	• Chino Valley Medical Center • Montclair Hospital Medical Center
San Antonio Regional Hospital	• Chino Valley Medical Center • Kaiser Ontario Medical Center • Montclair Hospital Medical Center
St. Bernardine Medical Center	• Colorado River Medical Center • Community Hospital of San Bernardino • Kaiser Fontana Medical Center • Mountains Community Hospital
St. Mary Medical Center	• Barstow Community Hospital • Bear Valley Community Hospital • Hi-Desert Medical Center • Robert E. Bush Naval Hospital-29 Palms • Victor Valley Global Medical Center

TRAUMA CENTER (TC)	REFERRAL HOSPITAL (SRH)
Arrowhead Regional Medical Center	• Barstow Community Hospital • Chino Valley Medical Center • Desert Valley Medical Center • Kaiser Fontana • Kaiser Ontario • Mammoth Hospital • Montclair Hospital Medical Center • Northern Inyo Hospital • San Antonio Regional Hospital • Southern Inyo Hospital • St. Bernardine Medical Center
Loma Linda University Medical Center	• Bear Valley Community Hospital • Colorado River Medical Center • Hi Desert Medical Center • Mountains Community Hospital • Redlands Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Robert E. Bush Naval Hospital-29 Palms • St. Mary Medical Center • Victor Valley Global Medical Center • Weed Army Hospital
Loma Linda University Children's Hospital	• Regional Pediatric Trauma Center

VII. REFERENCES

Number	**Name**
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Destination Policy
6100	Neurovascular Stroke Receiving Centers Destination Policy (San Bernardino County Only)
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)
15030	Trauma Triage Criteria

DESTINATION POLICY

I. PURPOSE

To ensure the transportation of 9-1-1patients to the most appropriate receiving facility that has the staff and resources to deliver definitive care to the patient. Destination may be determined by patient's need for specialty care services, such as those provided by designated trauma, STEMI, stroke centers.

II. DEFINITIONS

Aircraft Dispatch Center (ADC): An ICEMA designated dispatch center which dispatches and coordinates air ambulance and/or air rescue aircraft response to the scene of a medical emergency within the ICEMA region.

Adult Patient: A person who is or is appearing to be older than 15 years of age.

Burn Patient: Patients meeting ICEMA's burn classifications minor, moderate or major, per ICEMA Reference #11100 - Burn - Adult (15 years of age or older) and #14070 - Burn - Pediatrics.

Critical Trauma Patient (CTP): Patients meeting ICEMA's trauma triage criteria per ICEMA Reference #15030 - Trauma Triage Criteria.

Neurovascular Stroke Receiving Center (NSRC): A licensed acute care hospital designated by ICEMA's Governing Board as a receiving hospital for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and /or management of stroke.

Neurovascular Stroke Base Hospital: Facilities that have been designated by ICEMA's Governing Board as a Neurovascular Receiving Hospital that also function as a base hospital.

Pediatric Patient: A person who is or is appearing to be under 15 years of age.

Pediatric Trauma Center: A licensed acute care hospital which usually treats (but is not limited to) persons under 15 years of age, designated by ICEMA's Governing Board that meets all relevant criteria, and has been designated as a pediatric trauma hospital, according to California Code of Regulations, Title 22, Division 9, Chapter 7, Section 100261.

ROSC: Return of spontaneous circulation.

Specialty Care Center: ICEMA designated trauma, STEMI, or stroke receiving centers.

ST Elevation Myocardial Infarction (STEMI): A medical term for a type of myocardial infarction that results in an elevation of the ST Segment on a 12-lead electro-cardiogram (ECG).

STEMI Base Hospital: Facilities that have emergency interventional cardiac catheterization capabilities that also function as a base hospital.

STEMI Receiving Center (SRC): A licensed general acute care hospital designated by ICEMA's Governing Board as a STEMI Receiving Center that has emergency interventional cardiac catheterization capabilities.

STEMI Referring Hospital: Facilities that do not have emergency interventional cardiac catheterization capabilities.

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

III. POLICY

If the patient's condition is stable, the most appropriate destination may be the facility associated with their healthcare plan and primary care physician.

If a patient requires specialty care at an ICEMA designated STEMI, Stroke, Trauma or other approved specialty center, the EMS provider may bypass closer facilities for another facility having the specialty services needed by the patient. Destination for specialty patients requires contact with an appropriate specialty base hospital.

Destination decisions should be based on patient condition or patient, guardian, family or law enforcement request. Patients unable to, or without a preference should be taken to the closest hospital unless their condition requires specialty services as described below.

If directed by the base hospital physician, an EMS transport provider may bypass a closer facility.

IV. GENERAL CONSIDERATIONS

- Closest Hospital
  - All patients requiring immediate medical attention for life threatening conditions.
  - Patients without destination preference.

- Patient Request
  - Patient requests should be honored if possible and appropriate.
  - Patient requests for specific destination may be accommodated if patient is medically stable and the destination is not significantly beyond the primary response area of the EMS transportation provider.
  - If a patient choses to bypass the recommended SRC, EMS field personnel must obtain an AMA and notify the STEMI base hospital.
- Higher Level of Care
  - May be dictated by patient condition and base hospital direction.
  - Allows ALS providers to bypass a closer facility in favor of a facility that has the capability of a specialty response to the patient's condition.
- Base Hospital
  - Final authority for destination determination is the base hospital.
  - Base hospital physician may override prior destination decisions made by the paramedic (EMT-P) or protocol.

IV. PSYCHIATRIC HOLDS

- All patients with a medical complaint on a psychiatric hold (5150) require medical evaluation and treatment and shall be transported to the closest acute care hospital for medical clearance.
- Any acute care hospital is capable of medically clearing psychiatric patients.
- Patients on a psychiatric hold with no medical complaints or conditions may be released to law enforcement for transport directly to a psychiatric facility that has the capacity to accept the patient.

V. DIVERSION (Refer to ICEMA Reference #8060 - Requests for Hospital Diversion Policy - San Bernardino County Only)

- Diversion of ALS ambulances is limited by ICEMA, refer to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).
- Ambulance diversion to another acute care hospital is not allowed in the ICEMA region based on hospital census or staffing.

- A patient may be directed to a hospital on diversion if it is in the best interest of the patient and the hospital has not declared an internal disaster.

- The base hospital determines final destination of Advanced Life Support (ALS) or Limited Advanced Life Support (LALS) patients.

- Basic Life Support (BLS) ambulances may not be diverted from their intended destination unless the hospital is on internal disaster.

VI. SPECIALTY CARE CENTERS

Specialty Care Center base hospital contact is **mandatory** for patients going to trauma, STEMI or stroke centers; and are the only authority that may change destination to another receiving hospital, trauma, STEMI or stroke center.

- SRCs:

  SRC is the preferred destination for STEMI identified patients based on machine interpretation of field 12-lead ECG, verified by EMT-Ps and approved by base hospital physician.

  - Once a patient with a STEMI has been identified, contact STEMI base hospital for destination decision and prepare patient for expeditious transport. Total transport time to the SRC is thirty (30) minutes or less. Base hospital physician may override this requirement and authorize transport to SRC with transport time greater than thirty (30) minutes.

  - In Inyo and Mono Counties, the assigned base hospital should be contacted for STEMI consultation.

  - In addition, patients with the following factors should be transported to the closest SRC. STEMI base hospital contact and consultation is required:

    - Obvious contraindication to thrombolytic therapy.

    - Cardiopulmonary arrest with sustained ROSC. Refer to ICEMA Reference #11070 - Cardiac Arrest - Adult.

  - STEMI Patients with the following factors should be transported to the closest paramedic receiving hospital. STEMI base hospital contact and consultation is required:

    - Unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest.

    - Malignant ventricular fibrillation, ventricular tachycardia, second degree type II heart block and third degree heart block.

- Hemodynamic instability as exhibited by systolic blood pressure less than 90 and/or signs of inadequate tissue perfusion.

- NSRCs: Refer to ICEMA Reference #11110 - Stroke Treatment - Adult (15 years of age and older).

  - Suspected stroke patients eligible for transport to NSRC will be identified using the mLAPSS triage criteria.

  - Once a patient with a stroke has been identified, contact a NSRC base hospital for destination decision and prepare the patient for expeditious transport. In Inyo and Mono Counties, the assigned base hospital should be contacted for stroke consultation.

  - If NSRC base hospital, is different from the NSRC, notify the NSRC of the patient's pending arrival as soon as possible to allow timely notification of the stroke team.

  - Identified acute stroke patients with "last seen normal" time plus transport time less than twelve (12) hours, or a "wake-up" stroke, transport to closest NSRC.

  - The following factor should be considered in determining choice of destination for acute stroke patients. NSRC base hospital contact and consultation is mandatory:

    - Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closest NSRC.

  - Identified acute stroke patients with "last seen normal" time equaling greater than twelve (12) hours or if "last seen normal time" is unknown, transport to closest paramedic receiving hospital.

  - Patients with the following factors should be transported to the closest receiving hospital. NSRC base hospital contact and consultation is required:

    - Unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest.

    - Hemodynamic instability and exhibiting signs of inadequate tissue perfusion.

- Trauma: (Refer to ICEMA Reference #15030 - Trauma Triage Criteria.)

  - Adult patients meeting trauma triage criteria shall be transported to the closest Trauma Center.

  - Transport pediatric patients meeting trauma triage criteria shall be transported to a pediatric Trauma Center when there is less than a twenty (20) minute difference in transport time between the pediatric Trauma Center and the closest Trauma Center.

  - Transport patients meeting the physiologic and/or anatomic criteria to the closest Trauma Center.

  - Patients meeting the mechanism of injury and either the physiologic or anatomic criteria will be transport to the closest Trauma Center.

  - If there are no associated physiologic or anatomic criteria and the potential trauma patient meets one or more of the mechanisms of injury contact a trauma base hospital to determine patient destination. Patient may be directed to a non-trauma receiving hospital.

  - Make trauma base hospital contact to determine if a Trauma Center should be the destination for patients not meeting the trauma triage criteria but meeting age and/or co-morbid factors.

  - Patients with unmanageable airway or traumatic cardiac arrest should be transported to the closest receiving hospital if indicated. Trauma base hospital contact shall be made.

- Burn: (Refer to ICEMA Reference #15030 - Trauma Triage Criteria.)

  - Burn patients meeting the physiologic or anatomic criteria for CTP shall be transported to the closest Trauma Center.

  - Burn patients meeting minor or moderate classifications shall be transported to the closest receiving hospital.

  - Burn patients meeting major burn classification may be transported to the closest burn center (in San Bernardino County contact Arrowhead Regional Medical Center).

  - Pediatric burn patients identified as a CTP should always be transported to the closest Trauma Center with or without burn capabilities. When there is less than twenty (20) minutes difference in transport time, a pediatric Trauma Center is the preferred destination.

- Burn patients with respiratory compromise, or potential for such, will be transported to the closest acute care receiving hospital for airway stabilization.

VII. INTERFACILITY TRANSFER (Refer to ICEMA Reference #8010 - Interfacility Transfer Guidelines)

- Patients will go to the designated destination facility regardless of patients' prior condition. Patients may only be diverted if patients' condition deteriorates significantly while in the care of EMS.

- Advanced EMTs and EMT-Ps may start prior-to- contact protocols before contacting the base hospital for change of destination if the patient's condition deteriorates significantly.

VIII. EMS AIRCRAFT ROTATION AND DESTINATION (San Bernardino County Only)

- All EMS Aircraft requests from the field in San Bernardino County will be dispatched by the ICEMA designated Aircraft Dispatch Center (ADC).

- The destination may be changed by the EMS providers based on patient requirements for specialty centers.

- Refer to ICEMA Reference #8070 - Aircraft Rotation Policy (San Bernardino County Only).

IX. REFERENCE

Number	Name
5050	Medical Response to a Multi-Casualty Incident Policy
6070	Cardiovascular STEMI Receiving Centers.
8010	Interfacility Transfer Guidelines
8060	Requests for Hospital Diversion Policy (San Bernardino County Only).
8070	Aircraft Rotation Policy (San Bernardino County Only)
11070	Cardiac Arrest - Adult
11100	Burn - Adult (15 years of age or older)
11110	Stroke Treatment - Adult
14070	Burn - Pediatrics
15030	Trauma Triage Criteria

TRANSPORT POLICY

(Inyo County Only)

I. PURPOSE

To provide guidelines for EMS field personnel for the transportation of patients in Inyo County.

II. POLICY

A. Ground Transport of Patients in Inyo County

- All patients originating in Independence (EOA 3) shall be transported to Northern Inyo Hospital (NIH) per ICEMA Reference #8130 - Destination Policy.

- All patients originating in Olancha/Cartago (EOA 5 and 6) shall be transported to Ridgecrest Regional Hospital (RRH) per ICEMA Reference #8130 - Destination Policy.

- Advanced Life Support (ALS) intercept may be used when available and only when the patient's condition requires a higher level of care.

- The receiving hospital shall be contacted as soon as possible according to ICEMA Reference #5040 - Radio Communication Policy.

- Base hospital physician may override prior destination decision by paramedic (EMT-P) per ICEMA Reference #8130 - Destination Policy.

NOTE: As a reference, Cottonwood Creek Bridge (halfway between Olancha/ Cartago and Lone Pine) is the mid-point between NIH and RRH.

B. Special Considerations

All patients originating in Lone Pine (EOA 4) that require a higher level of care:

- An ALS flight crew (Sierra Lifeflight) may be requested if ALS care is required.

- Simultaneously base hospital contact shall be made to base hospital who will determine (in collaboration with the ground and flight crew) whether:

  - Patient is transported via ground to NIH with ALS flight crew.

  - Patient is transported via air to Bishop and then by ground to NIH.

  - Patient is transported by air or ground to a hospital outside the county.

C. <u>Base Hospital Contact</u>

- Base hospital contact is required according to ICEMA Reference #5040 - Radio Communication Policy.

- All patients being considered for transport to hospitals other than NIH or RRH require NIH base hospital contact for medical control and destination decision.

- Patients requiring higher level of care such as that required by patient condition (trauma, stroke or STEMI), may be directed to a more distant facility by the base hospital.

- All patient destinations other than by ground transport require base hospital direction prior to transport.

D. <u>Patient Documentation and Quality Improvement (QI/QA)</u>

- EMS field personnel must complete an ICEMA approved electronic patient care record (ePCR) for all patients.

- All ePCRs will be reviewed as part of the EMS provider and base hospital review process.

III. REFERENCES

Number	Name
5040	Radio Communication Policy
8130	Destination Policy

AMBULANCE PATIENT OFFLOAD DELAY

I. PURPOSE

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

II. CONSIDERATIONS

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

III. DEFINITIONS

Ambulance Arrival at ED - The time the ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.

Ambulance Patient Offload Time - The interval between the arrival of an ambulance patient at an ED and the time that the patient is transferred to an ED gurney, bed, chair or other acceptable location and the ED assumes responsibility for care of the patient.

Ambulance Patient Offload Time Standard - Ambulance patient offload time standard of 25 minutes or less.

Ambulance Patient Offload Delay (APOD) - Any delay in ambulance patient offload time that exceeds the local ambulance patient offload time standard of 25 minutes. This shall also be synonymous with "non-standard patient offload time" as referenced in the Health and Safety Code.

Designated Receiving Hospital - A hospital that has been designated by the EMS Agency to receive EMS patients transported by ambulance.

Emergency Department (ED) Medical Personnel - An ED physician, mid-level practitioner (e.g., Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

EMS Field Personnel - EMTs, AEMTs and/or EMT-Ps responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.

Medical Triage - Medical sorting and prioritization of a patient by ED medical personnel. Medical triage includes acceptance of a verbal patient report from EMS field personnel.

Transfer of Patient Care - The orderly transition of patient care duties from EMS field personnel to receiving hospital ED medical personnel.

Unusual Event - An incident that significantly impacts or threatens public health, environmental health or emergency medical services.

Verbal Patient Report - The face-to-face verbal exchange of key patient information between EMS field personnel and ED medical personnel.

Written EMS Report - The written report supplied to ED medical personnel (either through the electronic patient care record (ePCR), or actual written report if ePCR is not available) that details patient assessment and care that was provided by EMS field personnel.

IV. DIRECTION OF EMS FIELD PERSONNEL

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

V. PATIENT CARE RESPONSIBILITY

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

VI. TRANSFER OF PATIENT CARE

Patients Under Care of EMS Field Personnel

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

patient offloading from the ambulance gurney exceeds the 25 minute standard, it will be documented and tracked as APOD.

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

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

VII. APOD MITIGATION PROCEDURES

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

ED medical personnel should consider the following to prevent APOD:

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

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

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

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

- Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD, including but not limited to:

- ➢ ED/Attending Physician
- ➢ ED Nurse Manager/Director or Designee (i.e., Charge Nurse)
- ➢ House Supervisor
- ➢ Administrator on call

- Processes to alert the following affected partners via ReddiNet when a condition exists that effects the timely offload of ambulance patients.

  - ➢ Local receiving hospitals/base hospitals
  - ➢ Fire department and ambulance dispatch centers

- Processes for ED medical personnel to immediately respond to and provide care for the patient if the attending EMS field personnel alert the ED medical personnel of a decline in the condition of a patient being temporarily held on the ambulance gurney.

EMS field personnel are directed to do the following to prevent APOD:

- Provide the receiving hospital ED with the earliest possible notification via two-way radio that a patient is being transported to their facility.

- Utilizing the appropriate safety precautions, walk-in ambulatory patients or use a wheelchair rather than an ambulance gurney if appropriate for the patient's condition.

- Provide a verbal patient report to the ED medical personnel within 25 minutes of arrival to the ED.

- Contact the EMS supervisor for direction if the ED medical personnel do not offload the patient within the 25 minute ambulance patient offload time standard.

- Complete the ICEMA required authorized patient care documentation.

- Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established in this policy.

VIII. CONTENT AND FORMATTING OF THE VERBAL PATIENT REPORT

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

Situation

- Patient age, sex, weight

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

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

Assessment
- Primary impression

Recommendations
- Treatment/interventions provided
- Patient response to treatment/interventions
- Request for orders (If it is a medical direction call)

IX. CLINICAL PRACTICES FOR EMS FIELD PERSONNEL TO REDUCE APOD

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

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

- Initiate vascular access only as clinically indicated. IV therapy should only be initiated pursuant to ICEMA treatment protocols for patients that require the following:

  a. Administration of IV medication(s), or
  b. Administration of IV fluid bolus or fluid resuscitation.

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

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

X. APOD UNUSUAL EVENTS

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

- Criteria for an APOD Unusual Event:

  - APOD exceeding 25 minutes is occurring, and;
  - The ambulance provider identifies and documents low EMS system ambulance availability due to APOD

<u>APOD Unusual Event Procedures</u>

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

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

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

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

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

GENERAL PATIENT CARE GUIDELINES

I. PURPOSE

To establish guidelines for the minimum standard of care and transport of patients.

II. DEFINITIONS

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

1. Altered level of consciousness.
2. Skeletal or soft tissue injuries.
3. Acute or chronic injury or disease process.
4. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
5. Evidence that the individual was subject to force that may cause injury.
6. Other condition that warrants evaluation and care at an acute care hospital.

Patient Contact: Determined to occur when any on duty BLS, LALS, or ALS field personnel (EMT, AEMT, EMT-P, RN) comes into the presence of a patient as defined above.

III. BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
    a. Airway, breathing and circulatory status.
    b. Subjective assessment of the patient's physical condition and environment.
    c. Objective assessment of the patient's physical condition and environment.

d. Vital signs (blood pressure, pulse, respiration, GCS, skin signs, etc.).

e. Prior medical history and current medications.

f. Any known medication allergies or adverse reactions to medications, food or environmental agents.

2. Initiate care using the following tools as clinically indicated or available:

a. Axial spinal immobilization.

b. Airway control with appropriate BLS airway adjunct.

c. Oxygen as clinically indicated.

d. Assist the patient into a physical position that achieves the best medical benefit and maximum comfort.

e. Automated External Defibrillator (AED).

f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated.

3. Assemble necessary equipment for ALS procedures or treatment under direction of EMT-P.

a. Cardiac monitoring.

b. IV/IO.

c. Endotracheal intubation.

4. Under EMT-P supervision, assemble pre-load medications as directed (excluding controlled substances).

IV. LIMITED ALS (LALS) INTERVENTIONS

1. Evaluation and continuation of all initiated BLS care.

2. Augment BLS assessment with an advanced assessment including, but not limited to the following:

a. Qualitative lung assessment.

b. Blood glucose monitoring.

3. Augment BLS treatment measures with LALS treatments as indicated by LALS protocols.

4. Initiate airway control as needed with the appropriate LALS adjunct.

5. Initiate vascular access as clinically indicated.

V. ALS INTERVENTIONS

1. Evaluation and continuation of all initiated BLS and/or LALS care when indicated by patient's condition.

2. Augment BLS and/or LALS assessment with clinically indicated advanced assessments including but not limited to the following:

   a. Cardiac monitor and/or 12-lead ECG.

   b. Capnography.

   c. Blood glucose monitoring.

3. Augment BLS and/or LALS treatment with advanced treatments as clinically indicated.

   a. Initiate airway control using an appropriate airway adjunct to achieve adequate oxygenation and ventilation.

   b. Initiate airway control only when clinically indicated for the appropriate administration of medications and/or fluids.

4. Review and evaluate treatments initiated by BLS, LALS, or ALS personnel.

   a. Consider discontinuing treatments not warranted by patient's clinical condition. Intermittent monitoring may be used instead of continuous monitoring when clinically indicated.

PHYSICIAN ON SCENE

PURPOSE

To establish criteria for an advanced emergency medical technician (AEMT), and paramedic (EMT-P) during situations in which a physician is physically present at the scene of a 9-1-1 response.

AUTHORITY

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

POLICY

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

PROCEDURE

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

1. The physician must be informed that Base Station contact must be made, and the final decision regarding the assumption of medical responsibility for patient care will be made by the Base Station physician.

2. The physician must show proper identification and a current California physician's license.

3. The physician must agree to sign the patient care report agreeing to take full responsibility for the care and treatment of the patient(s) involved in the incident and accompanies the patient(s) in the ambulance to the most appropriate receiving facility. This statement is available on the ICEMA e-PCR and on the back of the first (white) copy of the ICEMA Standard Run Report Form (01A). Prehospital EMS agencies using software not totally integrated with ICEMA software must provide a form stating the above and obtaining physician signature.

4. Care of the patient must be transferred to a physician at the receiving facility.

AEMT and EMT-P RESPONSIBILITIES

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

1. Notify Base Station that a physician has requested to take over patient.

2. Maintain control of drugs and equipment from the LALS or ALS unit. Inform the physician of drugs and equipment available.

3. Offer assistance to the physician on scene. The AEMT or EMT-P may only perform procedures that are within the ICEMA scope of practice.

4. Document on patient care report all necessary information and obtain physician signature.

RESPONSIBILITY FOR PATIENT MANAGEMENT POLICY

PURPOSE

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

AUTHORITY

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

PROCEDURE

1. An AEMT or EMT-P may transfer patient management responsibility to an EMT for transportation, **without Base Station direction**, only under the following conditions:

    a. When the patient does not meet criteria for Base Station contact and has not received ALS care.

    b. When operating under policy, ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident.

    c. When operating under ICEMA Reference #9060 - Local Medical Emergency Policy.

2. The Base Station should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.

3. In the event of radio communication failure, an LALS or ALS unit may not transfer patient management responsibility to an EMT for transportation.

REFERENCES

Number	Name
5050	Medical Response to a Multi-Casualty Incident
9060	Local Medical Emergency Policy

REPORTING INCIDENTS OF SUSPECTED ABUSE POLICY

PURPOSE

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

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

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

CHILD ABUSE/NEGLECT

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

1. Name of person making report.

2. Name of child.

3. Present location of child.

4. Nature and extent of the abuse/neglect.

5. Location where incident occurred, if known.

6. Other information as requested.

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

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

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

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

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

Inyo County: CPS
162 Grove St. Suite "J"
Bishop, CA 93514

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

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

DEPENDENT ADULT AND ELDER ABUSE/NEGLECT

Suspicion of dependent adult and elder abuse/neglect should be reported as soon as possible by telephone. Be prepared to give the following information:

1. Name of person making report.

2. Name, address and age of the dependent adult or elder.

3. Nature and extent of person's condition.

4. Other information, including information that led the reporter to suspect either abuse or neglect.

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

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

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

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

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

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

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

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

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

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

Administrative Office **Receives All Reports of Abuse:** **San Bernardino County** **Department of Aging and Adult Services** **686 E. Mill St.** **San Bernardino, CA 92415-0640** **909-891-3928 Office** **1-866-229-0284 Reporting** **Fax 909-891-3957**	**The State CRISIS line number:** **1-800-231-4024** **This CRISIS line is available to take calls and refer complaints 24 hours a day, 7 days a week.**

ORGAN DONOR INFORMATION

PURPOSE

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

AUTHORITY

California Health and Safety Code, Section 7152.5 (b).

DEFINITIONS

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

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

POLICY

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

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

2. All EMS field personnel shall notify the receiving hospital if organ donor information is discovered.

3. Any organ donor document discovered should be transported to the receiving hospital with the patient unless the investigating law enforcement officer requests the document. In the event that no transport is made, any document should remain with the patient.

4. EMS field personnel should briefly note the results of the search, notification of hospital and witness name(s) on the patient care report.

5. No search is to be made by EMS field personnel after the patient has expired.

LOCAL MEDICAL EMERGENCY POLICY

I. PURPOSE

To provide guidelines to EMS field personnel regarding the treatment and transportation of patients during a declared Local Medical Emergency.

II. POLICY

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

III. DEFINITION

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

IV. PROCEDURES

The following procedures shall apply during a Local Medical Emergency:

A. A public safety agency of the affected jurisdiction shall notify the County Communications Center of the proclamation of a local emergency, and shall provide information specifying the geographical area that the proclamation affects.

B. The Communications Center shall notify:

- The County Health Officer/Designee.
- ICEMA Duty Officer.
- The County Sheriff's Department.
- Area EMS providers.
- Area hospitals.

C. This policy shall remain in effect for the duration of the declared Local Medical Emergency or until rescinded by the Medical and Health Operational Area Coordinator (MHOAC) which can be the County Health Officer and/or the EMS Agency Administrator or his/her designee.

V. MEDICAL CONTROL

A. BLS, Limited ALS, and ALS EMS field personnel may function within their Scope of Practice as established in the ICEMA Policy, Procedure, and Protocol Manual without Base Station contact.

B. No care will be given unless the scene is secured and safe for EMS field personnel.

C. Transporting EMS providers may utilize BLS units for patient transport as dictated by transport resource availability. In cases where no ambulance units are available, EMS field personnel will utilize the most appropriate method of transportation at their disposal.

D. Patients too unstable to be transported outside the affected area should be transferred to the closest secured appropriate facility.

E. County Communications Center should be contacted on the 700/800 MHz system for patient destination by the transporting unit.

F. Base Station contact criteria outlined in ICEMA Reference #5040 - Radio Communication Policy, may be suspended by the ICEMA Medical Director. EMS providers will be notified. Receiving facilities should be contacted with following information once en route:

- ETA.
- Number of patients.
- Patient status: Immediate, delayed or minor.
- Brief description of injury.
- Treatment initiated.

VI. DOCUMENTATION

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

- One section to be kept by the jurisdictional public safety agency. A patient transport log will also be kept indicating time, incident number, patient number (triage tag), and receiving facility.

- One section to be retained by the transporting EMS provider. A patient log will also be maintained indicating time, incident number, patient number (triage tag) and receiving facility.

- Remaining portion of triage tag to accompany patient to receiving facility which is to be entered into the patient's medical record.

- All Radio Communication Failure reports may be suspended for duration of the Local Medical Emergency.

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

VII. COUNTY COMMUNICATIONS CENTER

County Communications Center will initiate a Multi-Causualty Incident (MCI) according to ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident. This information will be coordinated with appropriate fire/rescue zone dispatch centers and medical unit leaders in the field as needed.

VIII. RESPONSIBILITIES OF THE RECEIVING FACILITIES

1. Receiving facilities upon notification by the County Communications Center of a declared Local Medical Emergency will provide hospital bed availability and Emergency Department capabilities for immediate and delayed patients.

2. Receiving facilities will utilize ReddiNet to provide the County Communications Center and ICEMA with hospital bed capacity status minimally every four (4) hours, upon request, or when capacities are reached.

3. It is strongly recommended that receiving facilities establish a triage area in order to evaluate incoming emergency patients.

4. In the event that incoming patients overload the service delivery capacity of the receiving hospital, it is recommended that the hospital consider implementing their disaster surge plan.

5. Saturated hospitals may request evacuation of stable inpatients. Movement of these patients should be coordinated by County Emergency Operations Center (EOC) and in accordance with local disaster response plans and if necessary, National Disaster Medical System categories.

IX. REFERENCES

Number	Name
5040	Radio Communication Policy
5050	Medical Response to a Multi-Casualty Incident

APPLYING PATIENT RESTRAINTS GUIDELINES

PURPOSE

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

AUTHORITY

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

PRINCIPLES

1. The safety of the patient, community and responding personnel is of paramount concern when following this policy.

2. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others.

3. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders.

4. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

5. Restraints should be applied by law enforcement whenever possible. If applied, an officer is required to remain available at the scene or during transport to remove or adjust the restraints for patient safety.

6. This policy is not intended to negate the need for law-enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene-management control.

PROCEDURE

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

1. Restraint equipment must be either padded leather restraints or soft restraints (e.g., posey, Velcro or seat-belt type). Both methods must allow for quick release.

2. EMS personnel shall **not** apply following forms of restraint:

   a. Hard plastic ties, any restraint device requiring a key to remove, hand cuffs or hobble restraints.

   b. Backboard, scoop stretcher or flat as a "sandwich" restraint.

   c. Restraining a patient's hands and feet behind the patient (e.g., hog-tying).

   d. Methods or other materials applied in a manner that could cause vascular or neurological compromise.

3. Restraint equipment applied by law enforcement (handcuffs, plastic ties or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest, and to take full tidal volume breaths.

4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene-management safety. The officer shall accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

5. Patients should be transported in a supine position if at all possible. EMS personnel must ensure that the patient's position does not compromise respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.

6. Restrained patients shall be transported to the most appropriate receiving facility within the guidelines of Protocol Reference #9030, Responsibility for Patient Management. The only allowable exception is a 5150 order presented when direct admission to a psychiatric facility has been arranged.

DOCUMENTATION

Documentation on the patient care form shall include:

1. The reasons restraints were needed.

2. Which agency applied the restraints (e.g., EMS, law enforcement).

3. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve and motor function every fifteen (15) minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation, and may be difficult to monitor.

4. Respiratory status should be evaluated for rate and quality every fifteen (15) minutes or more often as clinically indicated while restrained.

CARE OF MINORS IN THE FIELD

I. PURPOSE

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

II. DEFINITIONS

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

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

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

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

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

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

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

III. PROCEDURE

Treatment and/or Transport of Minors

- In the absence of a parent or legal representative, minors with an emergency condition shall be treated and transported to the medical facility most appropriate to the needs of the patient.

- In the absence of a parent or legal representative, minors with a non-emergency condition require EMS field personnel to make reasonable effort to contact a parent or legal representative before initiating treatment and/or

transport. If a parent or legal representative cannot be reached and minor is transported, EMS field personnel shall make every effort to inform the parent or legal representative of where the minor has been transported, and request that law enforcement accompany the minor patient to the hospital.

Minors Not Requiring Immediate Treatment and/or Transport

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

Minor Attempting to Refuse Indicated Care

- Attempt to contact parent or legal representative for permission to treat and/or transport.
- If parent or legal representative cannot be contacted, contact law enforcement and request minor to be taken into temporary custody for treatment and/or transport.

Base Hospital Contact

- Base hospital contact is required**,** prior to EMS field personnel leaving the scene, for the following situations:
  - Minors under the age of nine (9) whose parents or guardians are refusing care.
  - Minors who in the opinion of EMS field personnel, do not require treatment or transport.
- See ICEMA Reference -#8130 - Destination Policy.

IV. REFERENCE

Number	Name
8130	Destination Policy

PATIENT REFUSAL OF CARE - ADULT

I. PURPOSE

To provide direction for EMS field personnel when an individual refuses their advice that treatment and/or transport is indicated.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.220

III. DEFINITIONS

Against Medical Advice (AMA): A term used to when an individual refuses treatment and/or transport after EMS field personnel advise that it is indicated.

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

Emergency: A condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (California Health and Safety Code, Division 2.5, Section 1797.70).

IV. PRINCIPLE

If a competent, conscious patient or legal guardian refuses care offered, or requests to be transported to a hospital other than the nearest, medically appropriate facility, the patient's request should be honored, when possible.

All AMAs shall be fully documented to acknowledge that the individual may benefit from assessment, treatment and/or transport refused the advice of EMS field personnel. Documentation shall acknowledge that the advice is to protect the individual and the EMS services and that the decision was that of the individual.

EMS field personnel may refuse a request to transport a patient to a more distant facility that is outside of their service area provided they offer transportation to an appropriate medical facility. In the event the patient or legal guardian insists upon transport and the transporting ambulance agrees to transport to a more distant facility, the signature of the patient or legal guardian must be obtained on the patient care record and base hospital contact made.

V. CONSENT

1. Immediately required treatment should not be delayed to obtain consent.

2. An individual has the responsibility to consent to or refuse treatment. If he/she is unable to do so, consent is then considered implied.

3. In non-emergency cases, consent should be obtained from the individual.

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

VI. MEDICAL DECISION MAKING CAPACITY

1. An individual has medical decision making capacity if he or she:

   a. Is capable of understanding the nature and consequences of the proposed treatment and refusal of such treatment.

   b. Has sufficient emotional control, judgment and discretion to manage his or her own affairs

2. An individual having an understanding of what may happen if treated or not treated, and is oriented to person, place, time and purpose.

3. An individual with an altered level of consciousness will be unlikely to fulfill these criteria.

4. If the individual is not deemed mentally competent, the person should be treated and transported. Attempt to obtain law enforcement concurrence in these circumstances.

VII. REFUSAL OF CARE DOCUMENTATION

The following information should be carefully documented on the patient care record:

1. The individual’s chief complaint, mechanism of injury, level of orientation/level of consciousness.

2. Base hospital contact per ICEMA Reference #5040 - Radio Communication Policy.

3. Any medical treatment or evaluation needed and refused.

4. The need for emergency transportation; also if transport by means other than an ambulance could be hazardous due to the individual's injury or illness.

5. Individual advised that potential harm could result without emergency medical treatment and/or transport.

6. Individual provided with a refusal advice sheet, and if he or she would accept the refusal advice sheet.

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

V. REFERENCE

Number	Name
2010	Requirements for Patient Care Records
5040	Radio Communication Policy
9080	Care of Minors in the Field

TREATMENT OF PATIENTS WITH AIRBORNE INFECTIONS AND TRANSPORT RECOMMENDATIONS

PURPOSE

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

AUTHORITY

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

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs and Symptoms (may include)

1. Fever > 100°F (37.8 C).

2. Runny nose, cough, sore throat (or any combination).

3. May or may not have gastrointestinal symptoms.

PROCEDURE

Patient Care

1. Treatment for a symptomatic individual who is a confirmed case or a suspected case of infectious disease is supportive based upon assessment findings.

2. IV fluids and appropriate medications are to be initiated per established protocols.

3. Exacerbation of underlying medical conditions in patients should be considered, thoroughly assessed and treated per established protocols.

Infection Control of Ill Persons During Treatment and Transport

1. EMS personnel should incorporate rapid assessment of potential infectious environment into their scene survey/safety and maintain an index of suspicion for infectious disease when a patient with signs/symptoms consistent with the case definition(s) is encountered.

2. Personal Protective Equipment (PPE) must be immediately accessible and employed by all EMS providers who come into close contact with ill and/or

infectious patients as outlined in the California ATD Standard. This would include the driver in vehicles with open driving compartments particularly when the patient is receiving aerosolized treatment.

3. All required care should be provided to the patient(s) as indicated by protocol(s).

4. Patients with suspected or confirmed case-status should be transported as warranted by assessment findings. All patients in acute respiratory distress will be transported. If transport is initiated, symptomatic patients should not be transported with non-symptomatic patients. The patient should be accompanied by a single attendant during transport to limit exposure unless patient treatment needs dictate otherwise.

5. After thorough assessment and attention to the patient's respiratory status, the patient should be encouraged to wear a surgical mask if it can be tolerated or oxygen mask if indicated. Close monitoring of the patient's respiratory status is required at all times during treatment and transport.

Specific EMS Personal Protective Equipment Standards and Transport Recommendations

1. For EMS personnel treating and/or transporting a patient that meets the case definition of infectious respiratory disease, protection must include wearing a fit-tested N95 respirator (or higher), disposable gloves and eye protection (face shield or goggles).

2. The ambulance ventilation system should be operated in the nonrecirculating mode, and the maximum amount of outdoor air should be provided to facilitate dilution. If the vehicle has a rear exhaust fan, use this fan during transport. If the vehicle is equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle, use this unit to increase the number of Air Changes per Hour (ACH). Air should flow from the cab (front of vehicle), over the patient, and out the rear exhaust fan. If an ambulance is not used, the ventilation system for the vehicle should bring in as much outdoor air as possible, and the system should be set to nonrecirculating. If possible, physically isolate the cab from the rest of the vehicle, and place the patient in the rear seat. [1]

3. Clean hands thoroughly with soap and water or an alcohol-based hand gel before and after all patient contacts.

4. All equipment and surface areas should be thoroughly decontaminated with an anti-bacterial cleaner following each patient contact.

[1] Centers for Disease Control, *MMWR* December 30, 2005 / 54(RR17);1-141

NAUSEA AND VOMITING

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Nausea.
- Vomiting.
- Prophylactic treatment of narcotic induced nausea and/or vomiting.

II. CONTRAINDICATIONS

Patients under four (4) years of age.

Known sensitivity to Ondansetron or other 5-HT3 antagonists:

- Granisetron (Kytril)
- Dolasetron (Anzemet)
- Palonosetron (Aloxi)

III. ALS PROCEDURE

- Assess patient for need for anti-emetic therapy.
- Maintain airway.
- Position of comfort.
- Oxygen.
- Cardiac monitoring in patients with history of cardiac problems.
- Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.

IV. DOCUMENTATION

Document patient response.

PROCEDURE - STANDARD ORDERS

12-lead Electrocardiography (EMT-P)

- ECG should be performed prior to medication administration.
- ECG should be performed on any patient whose medical history and/or presenting symptoms are consistent with acute coronary syndrome including typical or atypical chest pain, syncopal episode, prior AMI, heart disease, or other associated risk factors.

Axial Spinal Immobilization (EMT, AEMT and EMT-P)

- Should be placed if patient meets the indicators , per ICEMA Reference #15010 - Trauma - Adult (Neuro Deficits present, Spinal Tenderness present, Altered Mental status, Intoxication, or Distracting Injury).
- An AEMT and/or EMT-P may remove if placed by BLS crew and it does not meet indicators.

Continuous Positive Airway Pressure Device (CPAP) - Adult (EMT, AEMT and EMT-P)

- Start at lowest setting and increase slowly until patient experiences relief or until a maximum of 15 cm H_2O is reached.

External Jugular Vein Access (AEMT and EMT-P)

- Not indicated for patients eight (8) years of age and younger.
- Patient condition requires IV access and other peripheral venous access attempts are unsuccessful.

Intraosseous Insertion (AEMT pediatric patients only and EMT-P)

- EMT-Ps may administer Lidocaine slowly per ICEMA Reference #7040 - Medication - Standard Orders, to control infusion pain.
- Approved insertion sites:
  - Eight (8) years of age or younger (LALS and ALS):
    - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.

- Nine (9) years of age and older (ALS only):
  - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.
  - Distal Tibia - Lower end of tibia, 2 cm above the medial malleolus.
  - Humeral Head (EZ IO only).
  - Anterior distal femur, 2 cm above the patella - Base hospital contact only.

- Leave site visible and monitor for extravasation.

King Airway Device (Perilaryngeal) - Adult (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - Patients 15 years or older.
  - Anyone over four (4) feet in height.
- Additional considerations:
  - Medications may **not** be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

King Airway Device (Perilaryngeal) - Pediatric (less than 15 years of age) (EMT Specialty Program, AEMT, and EMT-P)

- Use of King Airway adjunct may be performed only on those patients who meet **all** of the following criteria:
  - Unresponsive, agonal respirations (less than six (6) breaths per minute) or apneic.
  - No gag reflex.
  - Pediatric patients meeting the following criteria:
    - 35 - 45 inches or 12 - 25 kg: size 2
    - 41 - 51 inches or 25 - 35 kg: size 2.5

- Additional Considerations:
  - Medications may NOT be given via the King Airway.
  - King Airway adjunct should not be removed unless it becomes ineffective.

Nasogastric/Orogastric Tube (EMT-P)

- Use viscous Lidocaine gel per ICEMA Reference #7040 - Medication - Standard Orders, for conscious patients.
- Required for all full arrest patients.

Nasotracheal Intubation (EMT-P)

- Absolute contraindication: Apnea.
- Base hospital contact required: Facial trauma, anticoagulant therapy, airway burns, failed CPAP.
- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for suspected head/brain injury.
- Administer Phenylephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to place ET after a maximum of three (3) nasotracheal intubation attempts or if unable to adequately ventilate patient via BVM.

Needle Cricothyrotomy (EMT-P)

- Absolute contraindication: Transection of the distal trachea.
- Monitor end-tidal CO_2 and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to ventilate adequately and transport immediately to the closest hospital for airway management.

Needle Thoracostomy (EMT-P)

- In blunt chest trauma consider bilateral tension pneumothorax if pulse oximetry (SpO_2) reading remains low with a patent airway or with poor respiratory compliance.

Oral Endotracheal Intubation - Adult (EMT-P)

- Immediately prior to intubation, consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for head injury.

- Monitor end-tidal CO_2 and wave form capnography.

- Monitor pulse oximetry.

- If unable to place ET after a maximum of three (3) intubation attempts (an attempt is considered made when tube passes the gum line) and, if all procedures to establish an adequate airway fail, consider Needle Cricothyrotomy.

- Document verification of tube placement (auscultation, visualization, capnography)

Synchronized Cardioversion (EMT-P)

- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety.

- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.

- If rhythm deteriorates to v-fib, turn off the sync button and defibrillate.

- Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines. Procedure may be repeated at 200, 300 and 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.

- In Radio Communication Failure or with base hospital order, repeated cardioversion attempts at 360 joules or clinically equivalent biphasic energy level per manufacturer's guidelines may be attempted.

Transcutaneous Cardiac Pacing (EMT-P)

- Start at a rate of sixty (60) and adjust output to the lowest setting to maintain capture. Assess peripheral pulses and confirm correlation with paced rhythm.

- Reassess peripheral pulses. Adjust output to compensate for loss of capture.
- Increase rate **(not to exceed 100)** to maintain adequate tissue perfusion.
- Consider Midazolam per ICEMA Reference #7040 - Medication - Standard Orders, for anxiety
- Consider Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders, for pain.
- Contact the base hospital if rhythm persists or for continued signs of inadequate tissue perfusion.

Vagal Maneuvers (EMT-P)

- Relative contraindications for patients with hypertension, suspected STEMI, or suspected head/brain injury.
- Reassess cardiac and hemodynamic status. Document rhythm before, during and after procedure.
- If rhythm does not covert within ten (10) seconds, follow ICEMA Reference #11050 -Tachycardias - Adult.

RESPIRATORY EMERGENCIES - ADULT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Symptoms of chronic pulmonary disease, wheezing, cough, pursed lip breathing, decreased breath sounds, accessory muscle use, anxiety, ALOC or cyanosis.

II. BLS INTERVENTIONS

- Reduce anxiety, allow patient to assume position of comfort.
- Administer oxygen as clinically indicated, obtain O_2 saturation on room air, or on home oxygen if possible.

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O_2 saturation on room air or on home oxygen if possible.
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O_2 saturation on room air or on home oxygen if possible.
- Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Consider advanced airway, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

ACUTE ASTHMA/BRONCHOSPASM/ALLERGIC REACTION/ANAPHYLAXIS

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus one (1) time.
- If no response to Albuterol, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Contact base hospital for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
- May repeat Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, after 15 minutes one (1) time.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Albuterol, with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.

- For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus until signs of improved tissue perfusion.

- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.

- If no response to Albuterol, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Contact base hospital for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.

- May repeat Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders after 15 minutes one (1) time.

- For suspected allergic reaction, consider Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders.

- For persistent severe anaphylactic shock, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.

- Consider advanced airway, refer ICEMA Reference #10190 - ICEMA Approved Skills.

- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

ACUTE PULMONARY EDEMA/CHF

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

- Reduce anxiety, allow patient to assume position of comfort.

- Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask.

- Be prepared to support ventilations as clinically indicated.

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Nitroglycerine per ICEMA Reference #7040 - Medication - Standard Orders. Do not use or discontinue NTG in presence of hypotension (SBP <100).
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders, if nitro is not working.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Nitroglycerine per ICEMA Reference #7040 - Medication - Standard Orders.
- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Consider advanced airway, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.
- In radio communication failure (RCF), the following medications may be utilized:
  - Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
  - Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders after patient condition has stabilized.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

AIRWAY OBSTRUCTION - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTION

RESPONSIVE

- Assess for ability to speak or cough (e.g., "Are you choking?").
- If unable to speak, administer abdominal thrusts (if the rescuer is unable to encircle the victim's abdomen or the patient is in the late stages of pregnancy, utilize chest thrusts) until the obstruction is relieved or patient becomes unconscious.
- After obstruction is relieved, reassess and maintain ABC's.
- Administer oxygen therapy; obtain O_2 saturation.
- If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

UNRESPONSIVE

- Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
- Begin immediate CPR at a 30:2 ratio for two (2) minutes.
- Each time the airway is opened to ventilate, look for an object in the victim's mouth and if found, remove it.
- If apneic and able to ventilate, provide one (1) breath every five (5) to six (6) seconds.
- Place AED on patient.

IV. LIMITED ALS (LALS) INTERVENTION

UNRESPONSIVE

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

V. ALS INTERVENTION

UNRESPONSIVE

- If apneic and able to ventilate, establish advanced airway.
- If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
- If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy, refer ICEMA Reference #10190 - ICEMA Approved Skills.

VI. REFERENCE

Number	Name
10190	ICEMA Approved Skills

BRADYCARDIAS - ADULT

STABLE BRADYCARDIA

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish vascular access if indicated. If lungs sound clear, consider bolus of 300 cc NS, may repeat.
- Monitor and observe for changes in patient condition.

IV. ALS INTERVENTIONS

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

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

UNSTABLE BRADYCARDIA

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish vascular access if indicated by inadequate tissue perfusion.
  - Administer IV bolus of 300 cc NS, may repeat one (1) time.
  - Maintain IV rate at TKO after bolus.
- Monitor and observe for changes in patient condition.
- Contact base hospital if need for further medical control.

IV. ALS INTERVENTIONS

- Administer IV bolus of 300 cc. Maintain IV rate at 300 cc per hour if lungs remain clear to auscultation.
- Place on cardiac monitor and obtain rhythm strip for documentation. If possible, obtain a 12-lead ECG to better define the rhythm. Provide copy to receiving hospital.
- Administer Atropine per ICEMA Reference #7040 - Medication -Standard Orders.
- If Atropine is ineffective or, for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block, utilize Transcutaneous Cardiac Pacing, per ICEMA Reference #10190 ICEMA Approved Skills.
- Consider Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
- Contact base hospital if interventions are unsuccessful.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

TACHYCARDIAS - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Signs and symptoms of poor perfusion.
- Heart rate greater than 150 beats per minute (bpm).

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Recognition of heart rate greater than 150 bpm.
- Place AED pads on patient as a precaution in the event patient has sudden cardiac arrest.
- Initiate an IV with normal saline and administer 300 cc bolus to patient exhibiting inadequate tissue perfusion.
- Obtain blood glucose. If indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, **or**
  - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.

IV. ALS INTERVENTIONS

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

Narrow Complex Supraventricular Tachycardia (SVT)

- Initiate NS bolus of 300 ml IV.
- Valsalva/vagal maneuvers.
- Adenosine per ICEMA Reference #7040 - Medication - Standard Orders.
- Synchronized cardioversion, refer to ICEMA Reference #10190 - Procedure - Standard Orders.
- Contact base hospital.

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

- Consider Adenosine, per ICEMA Reference #7040 - Medication - Standard Orders, if the rate is regular and the QRS is monomorphic. Adenosine is contraindicated for unstable rhythms or if the rhythm is an irregular or polymorphic wide complex tachycardia.
- If Adenosine fails to convert the rhythm or is contraindicated, consider Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.
- Polymorphic VT should receive immediate unsynchronized cardioversion (defibrillation). Consider infusing Magnesium per ICEMA Reference #7040 - Medication - Standard Orders.
- Precordial thump for witnessed spontaneous VT, if defibrillator is not immediately available for use.
- Synchronized cardioversion, refer to ICEMA Reference #10190 - Procedure - Standard Orders.
- Contact base hospital.

Atrial Fib/Flutter

- Transport to appropriate facility.
- For patients who are hemodynamically unstable, proceed to synchronized cardioversion, refer to ICEMA Reference #10190 - Procedure - Standard Orders.
- Contact base hospital.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	Procedure - Standard Orders

SUSPECTED ACUTE MYOCARDIAL INFARCTION (AMI)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Chest pain (typical or atypical).
- Syncopal episode.
- History of previous AMI, Angina, heart disease, or other associated risk factors.

II. BLS INTERVENTIONS

- Recognition of signs/symptoms of suspected AMI.
- Reduce anxiety, allow patient to assume position of comfort.
- Oxygen as clinically indicated.
- Obtain O_2 saturation.
- May assist patient with self-administration of Nitroglycerin and/or Aspirin.

III. LIMITED ALS (LALS) INTERVENTIONS

- Aspirin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider early vascular access.
- For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, administer 300 ml NS bolus, may repeat.
- Nitroglycerin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider establishing a saline lock enroute on same side as initial IV.
- Complete thrombolytic checklist, if time permits.
- Contact base hospital.

IV. ALS INTERVENTIONS

- Aspirin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider early vascular access.
- For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, administer 300 ml NS bolus, may repeat.
- 12-Lead Technology:
  - Obtain 12-lead ECG. Do not disconnect 12-lead cables until necessary for transport.
  - If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, obtain a right-sided 12-lead (V4R).
  - If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300 ml NS bolus, may repeat. Early consultation with base hospital or receiving hospital in rural areas is recommended. (Nitrates are contraindicated in the presence of RVI or hypotension.)
  - With documented ST segment elevation in two (2) or more contiguous leads, contact STEMI base hospital for destination decision while preparing patient for expeditious transport, refer to ICEMA Reference #6070 - Cardiovascular "STEMI" Receiving Centers. In Inyo and Mono Counties, the assigned base hospital should be contacted for STEMI consultation.
  - Repeat 12-lead at regular intervals, but do not delay transport of patient. If patient is placed on a different cardiac monitor for transport, transporting provider should obtain an initial 12-lead on their cardiac monitor and leave 12-lead cables in place throughout transport.
  - EMS field personnel shall ensure that a copy of the 12-lead ECG is scanned or attached as a permanent part of the patient's ePCR or O1A and submit to ICEMA if patient is going to a SRC as a suspected STEMI.
- Nitroglycerin per ICEMA Reference #7040 - Medication - Standard Orders. Utilize Fentanyl for pain control when Nitroglycerin is contraindicated.

- Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders. Consider concurrent administration of Nitroglycerin with Fentanyl if there is no pain relief from the initial Nitroglycerin administration. Contact base hospital for further Fentanyl orders.

- Consider establishing a saline lock as a secondary IV site.

- Make early STEMI notification to the STEMI Receiving Center.

- In Radio Communication Failure (RCF), may administer up to an additional 100 mcg of Fentanyl in 50 mcg increments with signs of adequate tissue perfusion.

V. REFERENCES

Number	**Name**
6070	Cardiovascular "STEMI" Receiving Centers
7040	Medication - Standard Orders

CARDIAC ARREST - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- Establish advanced airway when resources are available, with minimal interruption to chest compressions. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.
- Establish peripheral intravenous access and administer a 500 ml bolus of normal saline (NS).
- Refer to ICEMA Reference #12010 - Determination of Death on Scene.

NOTE: Base hospital contact is <u>required</u> to terminate resuscitative measures.

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine cardiac rhythm and defibrillate if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IV/IO access.

- Establish advanced airway when resources are available, with minimal interruption to chest compressions. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.

- Utilize continuous quantitative waveform capnography, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status. Document the shape of the wave and the capnography number in mmHG.

- Insert NG/OG tube to relieve gastric distension per ICEMA Reference #10190 - Procedure - Standard Orders.

- If sustained ROSC is achieved, obtain a 12-lead ECG and contact a STEMI base hospital and transport to a SRC, refer to ICEMA Reference #8130 - Destination Policy.

- Utilize continuous waveform capnography, to identify loss of circulation.

- For continued signs of inadequate tissue perfusion after successful resuscitation, administer:

  - Dopamine per ICEMA Reference #7040 - Medication - Standard Orders to maintain signs of adequate tissue perfusion.

- Base hospital physician may order additional medications or interventions as indicated by patient condition.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use maximum available.

- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.

- Administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders during each two (2) minute cycle of CPR after every defibrillation unless capnography indicates possible ROSC.

- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as above.

- After two (2) cycles of CPR, consider administering:
  - Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.
- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base hospital.

Pulseless Electrical Activity (PEA) or Asystole

- Assess for reversible causes and initiate treatment.
- Continue CPR with evaluation of rhythm every two (2) minutes.
- Administer fluid bolus of 300 ml NS IV, may repeat.
- Administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders during each two (2) minute cycle of CPR after each rhythm evaluation.

Termination of Efforts in the Prehospital Setting

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

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
8130	Destination Policy
10190	ICEMA Approved Skills
12010	Determination of Death on Scene

ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

- Oxygen therapy as clinically indicated.
- Position patient as tolerated. If altered gag reflex in absence of traumatic injury, place in left lateral position.
- Place patient in axial spinal stabilization per ICEMA Reference #15010 - Trauma - Adult (15 years of age and older).
- If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

III. LIMITED ALS (LALS) INTERVENTIONS

- Obtain vascular access.
- Obtain blood glucose level. If indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, **or**
  - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV. May give one (1) time only.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.

- If suspected narcotic overdose with severely decreased respiratory drive administer:
  - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Assess and document response to therapy.
- Base hospital may order additional medication dosages and fluid bolus.

IV. ALS INTERVENTIONS

- Obtain vascular access and place on monitor.
- Obtain blood glucose level. If indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, **or**
  - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV. May give one (1) time only.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
- For tonic/clonic type seizure activity, administer:
  - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
  - Assess patient for medication related reduced respiratory rate or hypotension.
- If suspected narcotic overdose with severely decreased respiratory drive administer:
  - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Assess and document response to therapy.
- Base hospital may order additional medication dosages and fluid bolus.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
15010	Trauma - Adult (15 years of age and older).

SHOCK (NON-TRAUMATIC)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibits signs/symptoms of shock.
- Determine mechanism of illness.
- History of GI bleeding, vomiting, diarrhea.
- Consider hypoglycemia or narcotic overdose.

II. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, including perilaryngeal airway adjunct if indicated.
- Obtain O_2 saturation on room air or on home oxygen if possible.
- Place AED pads on patient as precaution in event patient goes into sudden cardiac arrest.
- Place in trendelenburg position if tolerated.
- Obtain vascular access.
- If hypotensive or have signs or symptoms of inadequate tissue perfusion, give fluid challenges:
  - ADULT
    - Administer 500 ml IV bolus, may repeat one (1) time until tissue perfusion improves
  - PEDIATRIC
    - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses, limb temperature transition, or altered level of consciousness.
- For patients with no respiratory difficulties and adequate signs of tissue perfusion:
  - ADULT/PEDIATRIC
    - Maintain IV at TKO.

III. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O_2 saturation on room air or on home oxygen if possible.

- Place on cardiac monitor.

- Place in trendelenburg if tolerated.

- Obtain vascular access.

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

  - ADULT
    - Administer 500 ml IV bolus, may repeat one (1) time to sustain a BP > 90 mmHg or until tissue perfusion improves.

  - PEDIATRIC
    - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses, limb temperature transition, or altered level of consciousness.

- For BP > 90 mmHg and no respiratory difficulties and adequate signs of tissue perfusion:

  - ADULT
    - Maintain IV rate at 150 ml per hour.

  - PEDIATRIC
    - Maintain IV at TKO.

<u>Base Hospital May Order</u>

- Establish 2nd large bore IV enroute.

- Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.

IV. REFERENCE

Number	Name
7040	Medication - Standard Orders

BURNS - ADULT
(15 years of age and older)

Burn patient requires effective communication and rapid transportation to the closest receiving hospital.

In Inyo and Mono Counties, the assigned base hospital should be contacted for determination of appropriate destination.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

- Break contact with causative agent (stop the burning process).
- Remove clothing and jewelry quickly, if indicated.
- Keep patient warm.
- Estimate % TBSA burned and depth using the "Rule of Nines".
  - ➢ An individual's palm represents 1% of TBSA and can be used to estimate scattered, irregular burns.
- Transport to ALS intercept or to the closest receiving hospital.

A. <u>Manage Special Considerations</u>

- **Thermal Burns**: Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns**: Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns**: Cool with water, do not remove tar.
- **Electrical Burns**: Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.

- **Eye Involvement**: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death On Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway as indicated.

- King Airway contraindicated in airway burns.

- Airway Stabilization:

  Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.

- IV access (warm IV fluids when available).

  - *Unstable:* BP <90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.

    IV NS 250 ml boluses, may repeat to a maximum of 1000 ml.

  - *Stable*: BP >90mmHG and/or signs of adequate tissue perfusion.

    IV NS 500 ml/hour.

- Transport to appropriate facility.

  - *Minor Burn Classification*: Transport to the closest most appropriate receiving hospital.

  - *Moderate Burn Classification*: Transport to the closest most appropriate receiving hospital.

  - *Major Burn Classification*: Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).

  - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate Trauma Center.

- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

A. Manage Special Considerations

- **Electrical Burns**: Place AED on patient.
  - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress**: Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP. Albuterol with Atrovent per ICEMA Reference #7040 -Medication - Standard Orders.
- **Deteriorating Vital Signs:** Transport to the closest most appropriate receiving hospital. Contact base hospital.
- **Pulseness and Apneic**: Transport to the closest most appropriate receiving hospital and treat according to ICEMA policies. Contact base hospital.
- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments**:
  - High flow oxygen is essential with known or potential respiratory injury. Beware of possible smoke inhalation.
  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
  - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
- **Base Hospital Orders**: May order additional fluid boluses.

IV. ALS INTERVENTIONS

- Advanced airway (as indicated).
- Airway Stabilization:

  Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.

- Monitor ECG.
- IV/IO Access (Warm IV fluids when available).
  - *Unstable:* BP <90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.

    IV/IO NS 250 ml boluses, may repeat to a maximum of 1000 ml.
  - *Stable*: BP >90mmHG and/or signs of adequate tissue perfusion.

    IV/IO NS 500 ml/hour.
- Treat pain as indicated.

  Pain Relief: Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders. Document BP and pain scale every five (5) minutes while medicating for pain and reassess the patient.
- Transport to appropriate facility:
  - *CTP with associated burns*, transport to the closest Trauma Center.
  - Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
- Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

A. <u>Manage Special Considerations</u>

- **Electrical Burns**: Monitor for dysrhythmias, treat according to ICEMA protocols.
  - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress**: Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
  - Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
  - Administer humidified oxygen, if available.

- Apply capnography.

- Awake and breathing patients with potential for facial/inhalation burns are not candidates for nasal tracheal intubation. CPAP may be considered, if indicated, after consultation with base hospital.

- **Deteriorating Vital Signs**: Transport to the closest receiving hospital. Contact base hospital.

- **Pulseness and Apneic**: Transport to the closest receiving hospital and treat according to ICEMA policies. Contact base hospital.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

- **Precautions and Comments**:

  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.

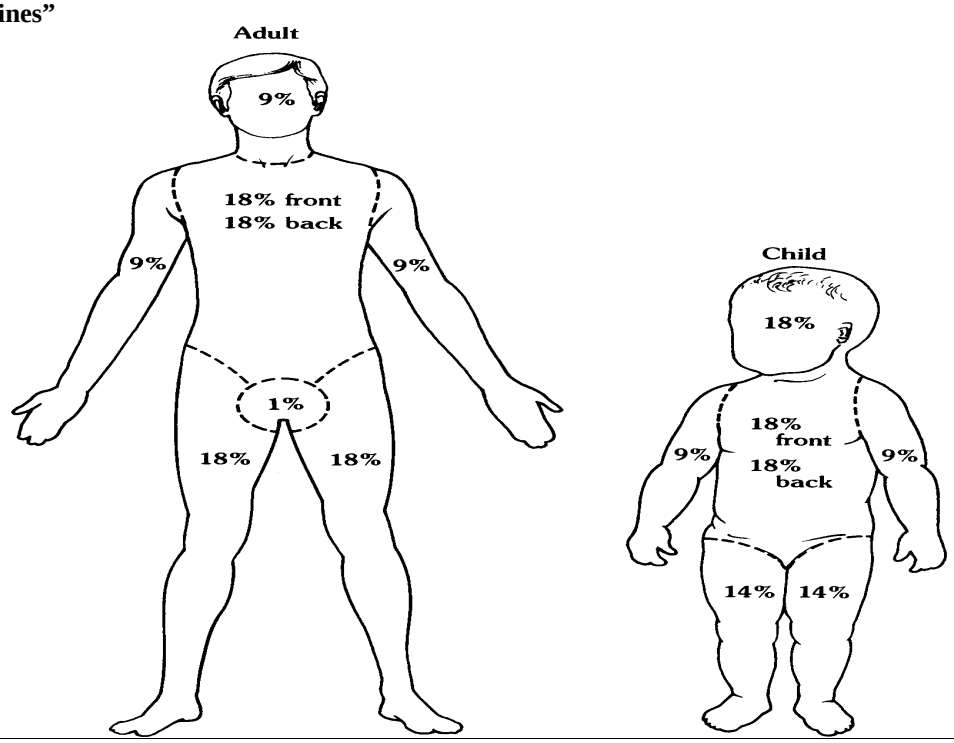
  - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.

- **Base Hospital Orders**: May order additional medications, fluid boluses and CPAP.

V. BURN CLASSIFICATIONS

ADULT BURN CLASSIFICATION CHART	DESTINATION	
MINOR - ADULT • < 10% TBSA • < 2% Full Thickness	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**	
MODERATE - ADULT • 10 - 20% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**	
MAJOR - ADULT • >20% TBSA burn in adults • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints	**CLOSEST MOST APPROPRIATE BURN CENTER** In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)	

"Rule of Nines"



VI. REFERENCES

Number	Name
7040	Medication - Standard Orders
9010	General Patient Care Guidelines
10190	ICEMA Approved Skills
11070	Adult Cardiac Arrest
12010	Determination of Death on Scene
15030	Trauma Triage Criteria and Destination Policy

STROKE TREATMENT - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibiting signs/symptoms of a possible stroke. These signs may include: speech disturbances, altered level of consciousness, parasthesias, new onset seizures, dizziness unilateral weakness and visual disturbances.

II. LIMITED ALS (LALS)/ALS INTERVENTIONS

- Vascular access.
- Obtain blood glucose.
- **Modified Los Angeles County Prehospital Stroke Screen (mLAPSS)**: A screening tool used by EMS field personnel to assist in identifying patients who may be having a stroke.

  mLAPSS Criteria: The patient is ***mLAPSS positive***, if "yes" on Criteria #1 - 4 *and* exhibits unilateral weakness on Criteria #6.

mLAPSS Criteria	**Yes**	**No**	
1. Age over 17 years?			
2. No prior history of seizure disorder?			
3. New onset of neurologic symptoms in last 24 hours?			
4. Patient was ambulatory at baseline prior to event?			
5. Blood glucose between 60 and 400?			
6. Exam (*look for obvious asymmetry):*	Normal-Bilaterally	Right	Left
• Facial Smile/Grimace	☐	☐ Droop ☐ Normal	☐ Droop ☐ Normal
• Grip	☐	☐ Weak Grip ☐ Normal	☐ Weak Grip ☐ Normal
	☐	☐ No Grip ☐ Normal	☐ No Grip ☐ Normal
• Arm Weakness	☐	☐ Drifts Down ☐ Normal	☐ Drifts Down ☐ Normal
		☐ Falls Down Rapidly ☐ Normal	☐ Falls Down Rapidly ☐ Normal

- Ask when “last seen normal” or without stroke symptoms.
- If “last seen normal” plus transport time is greater than twelve (12) hours, transport to the closest receiving hospital.
- If “last seen normal” plus transport time is less than twelve (12) hours, or a “wake-up stroke”, transport to closest NSRC.
- In San Bernardino County, if Stroke Scale is positive, initiate “Stroke Alert”, contact NSRC base hospital and transport immediately.
- If mLAPSS negative and stroke is still suspected, contact NSRC base hospital.
- Obtain and document on scene family phone number.
- Consider 12-lead ECG (ALS only).
- **Thrombolytic Assessment**: If time is available, and the patient or family can provide the information, assess the patient using the criteria listed below and report to ED personnel:

Thrombolytic Assessment Criteria	**Yes**	**No**
Onset greater than 4 hours?		
History of recent bleeding?		
Use of anticoagulant?		
Major surgery or serious trauma in the previous fourteen (14) days?		
Sustained systolic blood pressure above 185 mm Hg?		
Recent stroke or intracranial hemorrhage?		

DETERMINATION OF DEATH ON SCENE

I. PURPOSE

To identify situations when an EMT, AEMT or EMT-P may be called upon to determine death on scene.

II. POLICY

An EMT, AEMT or EMT-P may determine death on scene if **pulselessness and apnea** are present with any of the following criteria. The EMT-P is authorized to discontinue BLS CPR initiated at scene if a patient falls into the category of obvious death. If any ALS procedures are initiated, only the base hospital physician/designee may determine death in the field. In any situation where there may be doubt as to the clinical findings of the patient, BLS CPR must be initiated and the base hospital contacted, refer to ICEMA Reference #12020 - Withholding Resuscitate Measures. When death is determined, the County Coroner must be notified along with the appropriate law enforcement agency.

III. DETERMINATION OF DEATH CRITERIA

- Decomposition.
- Obvious signs of rigor mortis such as rigidity or stiffening of muscular tissues and joints in the body, which occurs any time after death and usually appears in the head, face and neck muscles first.
- Obvious signs of venous pooling in dependent body parts, lividity such as mottled bluish-tinged discoloration of the skin, often accompanied by cold extremities.
- Decapitation.
- Incineration of the torso and/or head.
- Massive crush injury.
- Penetrating injury with evisceration of the heart, and/or brain.
- Gross dismemberment of the trunk.

PROCEDURE

- If the patient does not meet the Determination of Death criteria, appropriate interventions must be initiated.

- Resuscitation efforts shall not be terminated en route per Government Code 27491. The patient will be transported to the closest facility where determination of death will be made by hospital staff.

- Most victims of electrocution, lightning and drowning should have resuscitative efforts begun and transported to the appropriate Hospital/Trauma Center.

- Hypothermic patients should be treated per ICEMA Reference #13030 - Cold Related Emergencies, under Severe Hypothermia.

- A DNR report form must be completed, if applicable, refer to ICEMA Reference #12020 - Withholding Resuscitative Measures.

- **San Bernardino County Only:**

  A copy of the patient care report must be made available for the Coroner. This will be transmitted to them, when posted, if the disposition is marked "Dead on Scene" and the Destination is marked "Coroner, San Bernardino County" on the electronic patient care report (ePCR). If unable to post, a printed copy of the ePCR, O1A or a completed *Coroners Worksheet of Death* must be left at the scene. The completed ePCR or 01A must be posted or faxed to the Coroner before the end of the shift.

LIMITED ALS (LALS) PROCEDURE

- All terminated LALS resuscitation efforts must have an AED event record attached to the patient care report.

- All conversations with the base hospital must be fully documented with the name of the base hospital physician who determined death, times and instructions on the patient care report.

ALS PROCEDURE

- All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the base hospital physician/designee.

- Severe blunt force trauma, pulseless, without signs of life (palpable pulses and/or spontaneous respirations) and cardiac electrical activity less than 40 bpm or during EMS encounter with the patient meets Determination of Death criteria.

- All terminated ALS resuscitation efforts must have an ECG attached to the patient care report.

- All conversations with the base hospital must be fully documented with the name of the base hospital physician who determined death, times and instructions on the patient care report.

IV. SUSPECTED SUDDEN INFANT DEATH SYNDROME (SIDS) INCIDENT

It is imperative that all EMS field personnel be able to assist the caregiver and local police agencies during a suspected SIDS incident.

PROCEDURE

- Follow individual department/agency policies at all times.

- Ask open-ended questions about incident.

- Explain what you are doing, the procedures you will follow, and the reasons for them.

- If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.

- Provide the parent/caregiver with the number of the California SIDS Information Line: **1-800-369-SIDS (7437)**

- Provide psychosocial support and explain the emergency treatment and transport of their child.

- Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.

- Document observations.

V. REFERENCES

Number	Name
12020	Withholding Resuscitative Measures
13030	Cold Related Emergencies

San Bernardino County Sheriff Department Coroner Division

EMS Report of Death

Time call was received: ——— Time of contact:———Time of death:———Unit #————

Name of who determined death and ICEMA #. _____

Patient's name, last, first: _____

DOB: ___/___/____

Patient's home address if different than location of call:

_____

Initial position how found:

_____

Treatment prior to determination of death: AED B L S A C L S

C/C or MOI:

_____

Signs of death: rigor mortis lividity skin temp (warm, cool, cold)

Trauma: no yes (describe)

_____

(Infants) damage to the frenulum: no yes (describe)

_____

Time Pt. last seen alive if known: _____

Medications: _____

Medical history : htn asthma cva chf copd diabetes psych seiz other: _____

Primary care physician: _____ Phone ( ) _____

Hospice: no yes D N R: no yes

Fax completed 01A form to (909) 387-2335

Legend:
AED: Automatic External Defibulator/BLS: Basic life support/ACLS: Advanced Cardiac life support MOI: mechanism of injury/C/C: Chief complaint

Government Code 27491

END OF LIFE CARE AND DECISIONS

I. PURPOSE

To establish criteria that recognizes and accommodates a patient's designated end of life directives to limit prehospital treatment by Emergency Medical Service (EMS) field personnel in the prehospital setting, long-term care facilities, during transport between facilities and/or in the patient's home.

II. DEFINITIONS

Absent Vital Signs: Absence of respiration and absence of carotid pulse.

Aid-In-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, who may choose to self-administer to bring about their death due to a terminal disease.

Advanced Directive: The California Advance Health Care Directive is a legal document in which a person specifies what actions should be taken for their health if they are unable to make decisions for themselves because of illness or incapacity. Advanced Directives may include:

- Power of Attorney for healthcare.
- Individual instructions for healthcare and/or organ donation in the event that the patient is unable to speak for themselves**.**
- Signatures and witnessing provisions.

Cardiopulmonary Resuscitation (CPR): Interventions intended to restore cardiac activity and respirations that include chest compressions, rescue breathing, and defibrillation.

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

- Chest compressions
- Defibrillation
- Endotracheal intubation

- Assisted ventilation
- Cardiotonic drugs, e.g., Epinephrine, Atropine or other medications intended to treat a non-perfusing rhythm

DNR Medallion/Bracelet/Necklace: A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA). There are currently only three (3) approved medallion providers for California. They are StickyJ Medical ID, MedicAlert Foundation and Caring Advocates.

End of Life Option Act: A California law that authorizes an adult, eighteen years of age or older, who satisfies certain conditions to request an "aid-in-dying drug" prescribed for the purpose of ending their life in a humane and dignified manner.

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

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

EMS field personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

The POLST complements an Advance Directive and is not intended to replace that document.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate patient's wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide EMSA/California Medical Association (CMA) Prehospital DNR form
- POLST form
- State EMS Authority-Approved DNR Medallion

Supportive Measures: Medical interventions used to provide and promote patient comfort, safety, and dignity. Supportive measures may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhage control
- Oral hydration
- Glucose administration
- Pain control (i.e., Fentanyl)

III. POLICY

EMS field personnel shall make all attempts to honor a patient's end of life wishes. In doing so, all efforts should be made to obtain and verify applicable forms describing the patient's end of life instructions and provide any necessary supportive measures.

A Do Not Resuscitate **(**DNR) order only applies to resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatments, nutrition or supportive measures. The treatment given to a patient with a DNR agreement should, in all respects, be the same as that provided to a patient without such an agreement.

A patient with medical decision making capacity can request alternative treatment or revoke a DNR or POLST by any means that indicates intent to revoke. A patient may withdraw or rescind their request for an aid-in-dying drug regardless of their mental state at any time.

Forms related to patient's end of life instructions that EMS field personnel may encounter include:

- Statewide EMSA/California Medical Association (CMA) Prehospital DNR form.
- POLST form.
- DNR medallion, bracelet or necklace.
- A Do Not Resuscitate Order in a patient's chart dated and signed by the physician.
- End of Life Options Act Directive and/or Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner form.

IV. VALIDATION CRITERIA

EMS Prehospital DNR

- The EMS Prehospital DNR form should include the following to be considered valid:
  - Patient's name.
  - Signature of the patient or a legally recognized decision maker if the patient is unable to make or communicate informed healthcare decisions.
  - Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
  - All signatures must be dated.
  - Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.
- In licensed healthcare facilities a DNR order written by a physician shall be honored.
  - The staff must have the patient's chart with the DNR order immediately available for EMS field personnel upon their arrival.
  - The order may contain the words Do Not Resuscitate, No CPR, or No Code and contain the patient's name and the date and signature of the physician.

DNR Medallion, Bracelet or Necklace

- The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:
  - Patient must be physically wearing the DNR medallion/ bracelet/necklace.
  - Medallion/bracelet/necklace must be engraved with the words "Do Not Resuscitate EMS" or "California POLST EMS", along with a toll free emergency information telephone number and a patient identification number.

Physician Order for Life Saving Treatment (POLST)

- The POLST does not replace the Advanced Directive and should be reviewed along with other documents when available. The POLST:
  - Must be signed and dated by a physician, nurse practitioner or physician assistant acting under the supervision of a physician and within the scope of practice authorized by law.
  - Must be signed by the patient or decision maker.
  - **Is not valid without signatures**. Verbal or telephone orders are acceptable with follow-up signature by the physician in accordance with facility/community policy. There should be a box checked indicating who the authorized healthcare provider discussed the POLST orders with. By signing the form, the healthcare provider acknowledges that these orders are consistent with the patient's medical condition and preferences.

End of Life Options Act Directive

- A terminally ill and competent patient may elect to obtain medications to hasten their imminent death at a time and place of their choosing. They must satisfy extensive and stringent requirements as required by California law to obtain an Aid-In-Dying Drug and complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" within 48 hours prior self-administration.

- There are no standardized "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation. If available, EMS field personnel should make a good faith effort to review and verify that the final attestation contains the following information:
  - The document is identified as a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner".
  - Patient's name, signature and dated.
  - EMS field personnel should review and verify that the "Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" is present.
  - Correctly identifies the patient's name, and is signed and dated by the patient or designated decision maker.
  - The Final Attestation for An Aid-In-Dying Drug must be completed within 48 hours prior to taking the medications.

- Obtain a copy of the final attestation and attach it to the electronic patient care record (ePCR) whenever possible.

- There is no mandate for the patient to maintain the final attestation in close proximity of the patient.

- If a copy of the final attestation is available, EMS field personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

V. PROCEDURE

DNR, Medallion/Bracelet/Neckless or POLST

In addition to the validation criteria, the following guidelines are provided for EMS field personnel when responding to a patient with Standardized Patient-Designated Directives.

- EMS field personnel shall validate the DNR request, medallion/bracelet/necklace, or POLST form. Patient may withdraw any directive at any time.

- The POLST may be used for both adults and pediatric patients.

- BLS field personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.

- LALS and ALS field personnel shall contact a base hospital for direction if a DNR or POLST cannot be validated or for conflicting requests by family members. While ALS field personnel are contacting the base hospital for direction, BLS treatment must be initiated and continued. If contact cannot be made, resuscitative efforts shall continue.

- If a patient states that they wish resuscitative measures, the request shall be honored.

- If a family member requests resuscitative measures despite a valid DNR or POLST, continue resuscitative measures until base hospital contact is made.

- If patient is not in cardiac arrest and has a valid POLST form, EMS field personnel may provide comfort measures as described in Section B of the form.

- The patient shall be transported to the hospital if comfort measures are started by EMS field personnel.

- Direct any questions or conflicts in transporting the patient to the base hospital.

- EMS field personnel shall attach a copy of the approved DNR form or POLST form to the patient care report, along with any other appropriate written documentation. The DNR form should accompany the patient to the hospital so that it may be incorporated into the medical record at the receiving facility.

- When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician's name. It should be noted on the ePCR that a written DNR order was present including the name of the physician, date signed and other appropriate information.

- All circumstances surrounding the incident must be documented on the EMS patient care report. If EMS field personnel are unable to copy the DNR or POLST form, the following shall be documented on the patient care report:

  - Presence of DNR or POLST form.

  - Date of order.

  - Name of physician who signed form.

- If a patient dies at home, and the patient is not under the care of Hospice, law enforcement must be notified. In all cases, the coroner must be notified. Refer to ICEMA Reference #12010 - Determination of Death On Scene.

- If a patient expires in a licensed healthcare facility, the facility has the responsibility to make the appropriate notification.

End of Life Options Act

In addition to the validation criteria, the following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

- The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients.

- Provide supportive measures whenever possible.

- Withhold resuscitative measures if patient is in cardiopulmonary arrest.

- The patient may withdraw or rescind their request for an aid-in-dying drug regardless of the patient's mental state at any time. EMS field personnel are encouraged to consult with their base hospital whenever necessary.

- Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If conflict arises as to resuscitation efforts, inform the family

that only supportive measures will be provided according to the patient's wishes and consider base hospital contact to attempt resolution.

- All circumstances surrounding the incident must be documented on the EMS patient care report. If EMS field personnel are unable to obtain a copy of the End of Life Options Act Final Attestation form, the following shall be documented on the patient care report:

  - Presence of the End of Life Options Act Attestation form.
  - Date of order.
  - Name of physician who signed form.

- If a patient dies at home and the patient is not under the care of Hospice, law enforcement must be notified. In all cases, the coroner must be notified. Refer to ICEMA Reference #12010 Determination of Death On Scene.

- If a patient expires in a licensed healthcare facility, the facility has the responsibility to make the appropriate notification.

VI. SUPPORTIVE MEASURES

- Medical interventions and/or treatment that may provide for the comfort, safety and dignity of the patient should be utilized.

- The patient should receive palliative treatment for pain, dyspnea, major hemorrhage or other medical conditions.

- Allow any family members/significant others to express their concerns and begin their grieving process.

- Unless a patient is actively dying, medical treatment for other conditions should not be withheld.

POISONINGS

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. PRIORITIES

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

III. BLS INTERVENTIONS

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

- Pertinent medical history, chronic illness, and/or medical problems within the last twenty-four (24) hours.
- Patient medication history.

- Monitor vital signs.
- Expeditious transport.

IV. LIMITED ALS (LALS) INTERVENTIONS PRIOR TO BASE HOSPITAL CONTACT

- Assure and maintain ABCs.
- Oxygen therapy as clinically indicated, obtain O_2 saturation on room air, unless detrimental to patient condition.
- Obtain vascular access at a TKO rate or if signs of inadequate tissue perfusion, administer 500 cc fluid challenge and repeat until perfusion improves.
- For pediatric patients with signs of inadequate tissue perfusion, administer 20 cc/kg IVP and repeat until perfusion improves.

V. ALS INTERVENTIONS PRIOR TO BASE HOSPITAL CONTACT

- Assure and maintain ABCs.
- Oxygen therapy as clinically indicated, obtain O_2 saturation on room air, unless detrimental to patient condition.
- Monitor cardiac status.
- Obtain vascular access at a TKO rate or if signs of inadequate tissue perfusion, administer 500 cc fluid challenge and repeat until perfusion improves.
- For pediatric patients with signs of inadequate tissue perfusion, administer 20 cc/kg IVP and repeat until perfusion improves.
- For phenothiazine “poisoning”, administer Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders for ataxia and/or muscle spasms.
- For known organophosphate poisoning, administer Atropine per ICEMA Reference #7040 - Medication - Standard Orders.

VI. BASE HOSPITAL MAY ORDER THE FOLLOWING

1.* For tricyclic poisonings, administer Sodium Bicarbonate per ICEMA Reference #7040 - Medication - Standard Orders.

2.* For calcium channel blocker poisonings, administer Calcium Chloride per ICEMA Reference #7040 - Medication - Standard Orders, if hypotension or bradycardic arrhythmias persist.

3.* For beta blocker poisonings, administer Glucagon per ICEMA Reference #7040 -Medication - Standard Orders.

4.* Repeat Atropine in 2 - 4 mg increments until symptoms are controlled.

* May be done during radio communication failure (RCF).

VII. REFERENCE

Number	Name
7040	Medication - Standard Orders

HEAT RELATED EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

MINOR HEAT ILLNESS SYNDROMES

- Environmental conditions.
- Increased skin temperature.
- Increased body temperature.
- General weakness.
- Muscle cramps.

HEAT EXHAUSTION (Compensated)

- All or some of the symptoms above.
- Elevated temperature.
- Vomiting.
- Hypotension.
- Diaphoresis.
- Tachycardia.
- Tachypnea.

HEAT STROKE (Uncompensated)

- All or some of the symptoms above.
- Hyperthermia.
- ALOC or other signs of central nervous system dysfunction.
- Absence or decreased sweating.
- Tachycardia.

- Hypotension.

HEAT EXHAUSTION/ HEAT STROKE

- Dehydration.
- Elevated temperature, vomiting, hypotension, diaphoresis, tachycardia and tachypnea.
- No change in LOC.

II. BLS INTERVENTIONS

- Remove patient from heat source, position with legs elevated and begin cooling measures.
- Oxygen as clinically indicated.
- Rehydrate with small amounts of appropriate liquids as tolerated. Do not give liquids if altered level of consciousness.
- If patient has signs of Heat Stroke, begin rapid cooling measures including cold packs placed adjacent to large superficial vessels.
- Evaporative cooling measures.

III. LIMITED ALS INTERVENTIONS

- Obtain vascular access.
  - ADULT
    - Fluid bolus with 500 cc NS. Reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.
  - PEDIATRIC
    - Patients less than nine (9) years of age: Initial 20 cc/kg IV bolus; reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.
- If clinically indicated, obtain blood glucose. If hypoglycemic administer:
  - ADULT/PEDIATRIC
    - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.

- Seizure precautions, refer to ICEMA Reference #11080 - Altered Level of Consciousness/Seizures - Adult.

- Contact base hospital for destination and further treatment orders.

IV. ALS INTERVENTIONS

- Obtain vascular access.

  - ADULT
    - Fluid bolus with 500 cc NS. May repeat fluid bolus if continued signs of inadequate tissue perfusion.

  - PEDIATRIC
    - Patients less than nine (9) years of age: Initial 20 cc/kg IV/IO bolus; reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.

- If clinically indicated, obtain blood glucose. If hypoglycemic administer:

  - ADULT/PEDIATRIC
    - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
    - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.

- Base hospital may order additional medication dosages and additional fluid boluses.

- Obtain rhythm strip for documentation with copy to receiving hospital.

- For tonic/clonic type seizure activity administer:

  - ADULT/PEDIATRIC
    - Midazolam per ICEMA Reference #7040 -Medication - Standard Orders.

V. REFERENCES

Number	**Name**
7040	Medication - Standard Orders
11080	Altered Level of Consciousness/Seizures - Adult

COLD RELATED EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

MILD HYPOTHERMIA

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

SEVERE HYPOTHERMIA

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

SUSPECTED FROSTBITE

- Areas of skin that is cold, white, and hard to touch.
- Capillary refill greater than two (2) seconds.
- Pain and/or numbness to affected extremity.

II. BLS INTERVENTIONS

- Remove from cold/wet environment; remove wet clothing and dry patient.
- Begin passive warming.

- Insulate and apply wrapped heat packs, if available, to groin, axilla and neck. This process should be continuous.

- Maintain appropriate airway with oxygen as clinically indicated (warm, humidified if possible).

- Assess carotid pulse for a minimum of one (1) to two (2) minutes. If no pulse palpable, place patient on AED. If no shock advised, begin CPR.

- Insulate to prevent further heat loss.

- Elevate extremity if frostbite is suspected.

- Do not massage affected extremity.

- Wrap affected body part in dry sterile gauze to prevent further exposure and handle with extreme care.

III. LIMITED ALS INTERVENTIONS

- Advanced airway as clinically indicated.

- Obtain vascular access.

- Obtain blood glucose level, if indicated administer:

  - ADULT/PEDIATRIC
    - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
    - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
    - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders if unable to establish IV.

- Obtain vascular access and administer fluid bolus.

  - Nine (9) years and older: 300 ml warmed NS, may repeat.

  - Birth to eight (8) years: 20 ml/kg warmed NS, may repeat.

- Contact base hospital.

IV. ALS INTERVENTIONS

- Obtain vascular access.

- Cardiac monitor.
- If clinically indicated, obtain blood glucose. If hypoglycemic administer:
  - ADULT/PEDIATRIC
    - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
    - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV.
- For complaints of pain in affected body part:
  - ADULT/PEDIATRIC
    - Fentanyl per ICEMA Reference #7040 -Medication - Standard Orders.
- In Radio Communication Failure, may repeat above dosage of Fentanyl.
- Advanced airway as clinically indicated.
- Obtain vascular access and administer fluid bolus.
  - Nine (9) years and older: 500 ml warmed NS, may repeat.
  - Birth to eight (8) years: 20 ml/kg warmed NS, may repeat.
- Obtain rhythm strip for documentation.
- For documented VF, Pulseless V-Tach:
  - Defibrillate one (1) time at manufacturer recommended dose. Do not defibrillate again until patient has begun to warm.
- For documented asystole:
  - Begin CPR.
  - May give additional fluid bolus.
- Contact base hospital.

V. REFERENCE

Number	**Name**
7040	Medication - Standard Orders

RESPIRATORY EMERGENCIES - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Asthma
- Toxic Inhalation
- Difficult Breathing

II. BLS INTERVENTIONS

- Assess environment and determine possible causes.
- If safe remove patient from any suspected contaminant.
- Recognize signs and symptoms of respiratory distress for age.
- Reduce anxiety, assist patient to assume position of comfort.
- Oxygen administration as clinically indicated (humidified oxygen preferred).

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Obtain vascular access at a TKO rate.
- If allergic reaction suspected, refer to ICEMA Reference #14030 - Pediatric Allergic Reaction (Less than 15 years of age).
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
  - Albuterol with Atrovent, per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol and Atrovent, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Obtain vascular access at a TKO rate.
- If allergic reaction suspected, refer to ICEMA Reference #14030 - Allergic Reactions - Pediatric (Less than 15 years of age).
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
14030	Allergic Reactions - Pediatric (Less than 15 years of age)

AIRWAY OBSTRUCTION - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Universal sign of distress.
- Sudden alteration in respiratory effort or signs of obstruction - coughing, gagging, stridor, wheezing, or apnea.
- Altered level of consciousness (for younger children this is measured by the inability to recognize caregiver, no aversion to being cared for by EMS field personnel, limp and/or ineffective cry).

II. BLS INTERVENTIONS

RESPONSIVE

- Assess for ability to cry, speak or cough (e.g., “are you choking?”).
- Administer abdominal thrusts (repeated cycles of five (5) back slaps and five (5) chest thrusts for infant less than one (1) year), until the foreign body obstruction is relieved or until patient becomes unresponsive.
- After obstruction is relieved, reassess and maintain ABCs.
- Obtain oxygen saturation on room air if possible.
- Administer oxygen.
- If responsive, place in position of comfort, enlisting help of child’s caregiver if needed. If child is uninjured but unresponsive with adequate breathing and a pulse, place in recovery position.

UNRESPONSIVE

- Position patient supine (for suspected trauma maintain in-line axial stabilization). Place under-shoulder support to achieve neutral cervical spinal position if indicated.
- Begin CPR, starting with thirty (30) compressions.

- Open airway using the head tilt-chin lift method (for suspected trauma, use jaw thrust). Remove object if visible.

- If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise or unable to ventilate, continue cycles of thirty (30) compressions to two (2) ventilations until obstruction is relieved or able to ventilate.

- If apneic and able to ventilate, provide one (1) breath every three (3) to five (5) seconds. Confirm that pulses are present and reassess every two (2) minutes.

III. LIMITED ALS (LALS) INTERVENTIONS

- If apneic and able to ventilate, consider King Airway placement per ICEMA Reference #10190 - Procedure - Standard Orders.

- If obstruction persists continue with compressions until obstruction is relieved or arrival at hospital.

- Transport to closest receiving hospital for airway management.

IV. ALS INTERVENTIONS

- If obstruction persists and unable to ventilate, attempt to visualize and remove visible foreign body with Magill forceps and attempt to ventilate.

- If obstruction persists, consider Needle Cricothyrotomy per ICEMA Reference #10190 - Procedure - Standard Orders.

V. REFERENCE

Number	**Name**
10190	Procedure - Standard Orders

ALLERGIC REACTIONS - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Signs and Symptoms of an acute allergic reaction.
- History of Exposure to possible allergen.

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS - PEDIATRIC (Less than 15 years of age)

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
- Establish additional IV access if indicated.
- Base hospital may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O_2 saturation on room air if possible.
- Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol and Atrovent, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
- Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders.
- Establish additional IV access if indicated.
- For anaphylactic shock (e.g., no palpable radial pulse and a depressed level of consciousness), administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital may order additional medication dosages and additional fluid boluses.

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

CARDIAC ARREST - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting. Consider the potential causes of arrest for age.

II. BLS INTERVENTIONS

- Assess patient, maintain appropriate airway; begin CPR according to current AHA Guidelines.
  - Ventilate at rate of 12 to 20 per minute. Ventilatory rate will decrease as patient age increases. Ventilatory volumes shall be the minimum necessary to cause chest rise.
  - Compression rate shall be a minimum of 100 per minute.
- If patient one (1) year of age or older, utilize AED.

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- Follow the instructions from the AED to determine if shock is advised.
- Obtain IO/IV access (IO is preferred for under nine (9) years of age).
- Establish advanced airway with minimal interruption to CPR, when resources are available.
- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
  - 1 day to 8 years: 20 ml/kg NS
  - 9 to 14 years: 300 ml NS

- Obtain blood glucose level, if indicated administer:
  - Dextrose as per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
  - Administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- If suspected narcotic overdose with severely decreased respiratory drive administer:
  - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine the cardiac rhythm and defibrillate at 2 j/kg (or manufacturer's recommended equivalent) if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IO/IV access (IO is preferred).
- Insert NG/OG tube after advanced airway is established or if not placed with BLS airway.
- Continue CPR with compressions at a minimum of 100 /min without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.
- Utilize continuous quantitative waveform capnography, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status.

<u>Ventricular Fibrillation/Pulseless Ventricular Tachycardia</u>

- Initial defibrillation is administered at 2 j/kg (or manufacturer's recommended equivalent). Second defibrillation is administered at 4 j/kg. Third and subsequent defibrillation attempts should be administered at 10 j/kg not to exceed the adult dose.

- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.

- Administer Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each defibrillation unless capnography indicates possible ROSC.

- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as indicated above.

- After two (2) cycles of CPR, consider administering Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders, may repeat.

- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base hospital.

Pulseless Electrical Activity/Asystole

- Assess for reversible causes and initiate treatment.

- Continue CPR with evaluation of rhythm every two (2) minutes.

- Administer initial fluid bolus of 20 ml/kg NS for all ages, may repeat at:

  - 1 day to 8 years: 20 ml/kg NS

  - 9 to 14 years: 300 ml NS

- Administer Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each rhythm evaluation.

Treatment Modalities for Managing Pediatric Cardiac Arrest Patient

Whenever possible, provide family members with the option of being present during the resuscitation of an infant or a child. For any termination of efforts, base hospital contact is required.

- Insert NG/OG tube to relieve gastric distention if the patient has an advanced or BLS airway per ICEMA Reference #10190 - Procedure - Standard Orders.

- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.

  - 1 day to 8 years: 20 ml/kg NS

  - 9 to 14 years: 300 ml NS

- Obtain blood glucose level. If indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
  - Naloxone for suspected opiate overdose per ICEMA Reference #7040 - Medication - Standard Orders.

If ROSC is achieved, obtain a 12-lead ECG.

- Utilize continuous waveform capnography, to identify loss of circulation.
- For continued signs of inadequate tissue perfusion **after** successful resuscitation:
  - Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
  - 9 to 14 years: Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	Procedure - Standard Orders

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibits inappropriate behavior for age.
- History or observation of an Apparent Life Threatening Event (ALTE).

II. BLS INTERVENTIONS

- Assess environment and determine possible causes for illness.
- Axial-spinal stabilization, if clinically indicated.
- Oxygen therapy, if clinically indicated.
- Airway management, as indicated (OPA/NPA, BVM Ventilation).
- Obtain patient temperature. Begin cooling measures if temperature is elevated or warming measures if temperature is decreased.

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish advanced airway as needed.
- Obtain vascular access.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS.
- Obtain blood glucose level, if indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
  - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.

- If suspected narcotic overdose with severely decreased respiratory drive administer:
  - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Establish advanced airway as needed.
- Obtain vascular access and place on cardiac monitor.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS. May repeat twice for continued signs of inadequate tissue perfusion.
- Obtain blood glucose level, if indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
  - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, if indicated.
  - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- If suspected narcotic ingestion with severely decreased respiratory distress administer:
  - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medication dosages and additional fluid boluses.

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

SEIZURE - PEDIATRIC
(Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish advanced airway as clinically indicated.
- Obtain vascular access.
- Obtain blood glucose level, if indicated administer:
  - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- ➢ May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
- ➢ Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.

IV. ALS INTERVENTIONS

- Establish advanced airway as clinically indicated.
- Obtain vascular access and place on cardiac monitor if indicated.
- Obtain blood glucose level, if indicated administer:
  - ➢ Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
  - ➢ May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
  - ➢ Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- For tonic/clonic type seizure activity administer:
  - ➢ Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
  - ➢ Assess and document response to therapy.
  - ➢ Base hospital may order additional medication dosages or a fluid bolus.

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

BURNS - PEDIATRIC
(Less Than 15 Years of Age)

Any burn patient requires effective communication and rapid transportation to the closest receiving hospital.

In Inyo and Mono Counties, the assigned base hospital should be contacted for determination of appropriate destination.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

- Break contact with causative agent (stop the burning process).
- Remove clothing and jewelry quickly, if indicated.
- Keep patient warm.
- Estimate percentage of total body surface area (TBSA) burned and depth using the "Rule of Nines". An individual's palm represents 1% of TBSA and can be used to estimate scattered, irregular burns.
- Transport to ALS intercept or to the closest receiving hospital.

A. <u>Manage Special Considerations</u>

- **Thermal Burns**: Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns**: Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns**: Cool with water, do not remove tar.
- **Electrical Burns**: Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.

- **Eye Involvement**: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Airway Stabilization (as indicated). Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- IV/IO Access (warm IV fluids when available).
  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.
  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
  - < 5 years of age: IV NS 150 ml/hour
  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

- Refer to Section V - Burn Classifications below.

A. <u>Manage Special Considerations</u>

- **Respiratory Distress**:
  - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
  - Administer humidified oxygen, if available.

- **Deteriorating Vital Signs**: Transport to the closest receiving hospital. Contact base hospital.

- **Pulseness and Apneic**: Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

- **Precautions and Comments**:

  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.

  - Do not apply ice or ice water directly to skin surfaces as additional injury will result.

  - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

IV. ALS INTERVENTIONS

- Establish advanced airway as clinically indicated.

  - Airway Stabilization: Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.

  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

  - < 5 years of age: IV NS 150 ml/hour

  - > 5 years of age - < 15 years of age: IV NS 250 ml/hour

- Treat pain as indicated.

  - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.

- Document vital signs every five (5) minutes while medicating for pain, and reassess the patient.

- Transport to appropriate facility:
  - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
  - Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

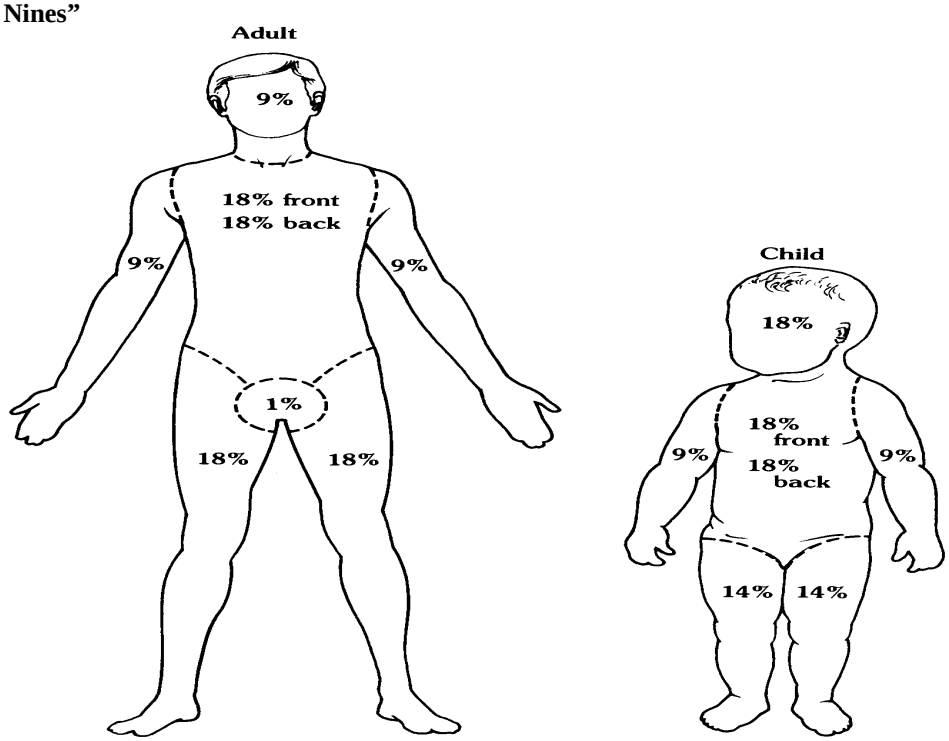
A. <u>Manage Special Considerations</u>

- **Respiratory Distress**: Establish advanced airway if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
  - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
  - Administer humidified oxygen, if available.
- **Deteriorating Vital Signs**: Transport to the closest receiving hospital. Contact base hospital.
- **Pulseness and Apneic**: Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.
- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments**:
  - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
  - Do not apply ice or ice water directly to skin surfaces as additional injury will result.
  - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

V. BURN CLASSIFICATIONS

PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
MINOR - PEDIATRIC • < 5% TBSA • < 2% Full Thickness	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MODERATE - PEDIATRIC • 5 - 10% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease)	**CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL**
MAJOR - PEDIATRIC • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints	**CLOSEST MOST APPROPRIATE BURN CENTER** In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)

"Rule of Nines"



VI. REFERENCES

Number	Name
7040	Medication - Standard Orders
8130	Destination Policy
12010	Determination of Death on Scene

OBSTETRICAL EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Obstetrical emergencies (field delivery) with or without complications.

II. BLS INTERVENTIONS

UNCOMPLICATED DELIVERY

- Administer oxygen as clinically indicated.
- Prepare for delivery.
- Massage fundus if placenta delivered.

COMPLICATED DELIVERY

- Excessive vaginal bleeding prior to delivery:
  - Attempt to control bleeding. Do not place anything into vagina.
  - Place in trendelenberg position.
- Prolapsed Cord:
  - Elevate hips.
  - Gently push presenting part of head away from cord.
  - Consider knee/chest position for mother.
- Postpartum Hemorrhage:
  - Massage fundus to control bleeding.
  - Encourage immediate breast feeding.
  - Place in trendelenburg position.
- Cord around infant's neck:
  - Attempt to slip cord over the head.

- ➢ If unable to slip cord over the head, deliver the baby through the cord.
- ➢ If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps.

- Breech presentation and head not delivered within three (3) to four (4) minutes:
  - ➢ Administer oxygen.
  - ➢ Place in trendelenburg position.
  - ➢ Transport Code 3 to closest appropriate facility.
- Pregnancy Induced Hypertension and/or Eclampsia:
  - ➢ Initiate and maintain seizure precautions.
  - ➢ Attempt to reduce stimuli.
  - ➢ Limit fluid intake.
  - ➢ Monitor and document blood pressure.
  - ➢ Consider left lateral position.

III. LIMITED ALS (LALS) INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
  - ➢ Give fluid challenge of 500 ml, if signs of inadequate tissue perfusion persist may repeat fluid bolus.
  - ➢ Maintain IV rate at 150 ml per hour.
  - ➢ Establish second large bore IV enroute.
- Pregnancy Induced Hypertension and/or Eclampsia:
  - ➢ IV TKO, limit fluid intake.
  - ➢ Obtain O_2 saturation on room air, if possible.

- Place in left lateral position, and obtain blood pressure after five (5) minutes.

- Consider immediate notification of base hospital physician.

IV. ALS INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
  - Administer fluid challenge of 500 ml. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
  - Maintain IV rate at 150 ml per hour.
  - Establish second large bore IV enroute.
- Pregnancy induced hypertension:
  - Administer IV TKO. Limit fluid intake.
  - Obtain O_2 saturation on room air, if possible.
  - Place in left lateral position, and obtain blood pressure after five (5) minutes.
  - Obtain rhythm strip with copy to receiving hospital.
- Eclampsia (Seizure/Tonic/Clonic Activity):
  - Magnesium Sulfate per ICEMA Reference #7040 - Medication - Standard Orders.
  - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider immediate notification of base hospital physician.
- Base hospital physician may order or in Radio Communication Failure:
  - Dopamine infusion per ICEMA Reference #7040 - Medication - Standard Orders.

V. REFERENCE

Number	Name
7040	Medication - Standard Orders

NEWBORN CARE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Field delivery with or without complications.

II. BLS INTERVENTIONS

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

APGAR SCORE

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Obtain vascular access via IV if indicated.

- Obtain blood glucose by heel stick.

  - If blood glucose < 35 mg/dL, administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- Contact base hospital if hypovolemia is suspected. Base hospital may order 10 ml/kg IV NS over five (5) minutes. If unable to contact base hospital and transport time is extended, administer 10 ml/kg IV NS over five (5) minutes, may repeat one (1) time.

IV. ALS INTERVENTIONS

- Obtain vascular access via IV/IO if indicated.

- Consider advanced airway, per ICEMA Reference #10190 - ICEMA Approved Skills, if BVM is ineffective or tracheal suctioning is required. Utilize Waveform Capnography to assess efficacy of compressions and ventilations. Place orogastric tube after advanced airway is in place. Reassess placement after every intervention.

- Obtain blood glucose by heel stick.

  - If blood glucose < 35 mg/dL, administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- Evaluate airway for hypoxemia and assess body temperature for hypothermia then consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders , if heart rate < 60 after one (1) minute.

- Contact base hospital if hypovolemia is suspected. Base hospital may order 10 ml/kg IV NS over five (5) minutes. If unable to contact base hospital and transport time is extended, administer 10 ml/kg IV NS over five (5) minutes, may repeat.

- For persistent hypotension despite adequate ventilation and fluid resuscitation, base hospital may order Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders, every ten (10) minutes. If unable to contact base hospital and transport time is extended, give indicated dosage and contact base hospital as soon as possible.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
10190	ICEMA Approved Skills

TRAUMA - ADULT
(15 years of age and older)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

In Inyo and Mono Counties, the assigned base hospital should be contacted for determination of appropriate destination.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O_2 saturation (if BLS equipped).
- Keep patient warm.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

A. <u>Manage Special Considerations</u>

- **Axial Spinal Immobilization**: If the patient meet(s) any of the following indicators using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  D-istracting Injury?

  - ➢ Consider maintaining spinal alignment on the gurney, or using axial spinal immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

- Penetrating trauma without any NSAID indicators are not candidates for axial spinal immobilization.

NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical. LBB does not need to be reapplied on interfacility transfer (IFT) patients.

- **Abdominal Trauma**: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.

- **Amputations**: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

  Partial Amputation: Splint in anatomic position and elevate the extremity.

- **Bleeding**:

  - Apply direct pressure and/or pressure dressing.

  - To control life-threatening bleeding of a severely injured extremity, consider application of tourniquet when direct pressure or pressure dressing fails.

- **Chest Trauma**: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.

- **Flail Chest**: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.

- **Fractures**: Immobilize above and below the injury. Apply splint to injury in position found except:

  - **Femur**: Apply traction splint if indicated.

- ➢ **Grossly angulated long bone with distal neurovascular compromise**: Apply gentle unidirectional traction to improve circulation.

- ➢ **Check and document distal pulse before and after positioning**.

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

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

  - ➢ **Eye**: Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe, stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.

  - ➢ **Avulsed Tooth**: Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

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

- **Pregnancy**: Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females $\geq$ 24 weeks of gestation.

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

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway (as indicated).

  - ➢ Unmanageable Airway: Transport to the closest most appropriate receiving hospital when the patient requires advanced airway and an adequate airway cannot be maintained with a BVM device.

- Apply AED.

- IV Access (warm IV fluids when available).

  - *Unstable*: BP<90mmHG and/or signs of inadequate perfusion, start 2nd IV access.

  - *Stable*: BP>90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

  - *Unstable*: IV NS open until stable or 2000 ml maximum is infused.

  - *Stable*: IV NS TKO

  Penetrating Trauma:

  - *Unstable*: IV NS 500 ml bolus one (1) time.

  - *Stable*: IV NS TKO

  Isolated Closed Head Injury:

  - *Unstable:* IV NS 250 ml bolus, may repeat to a maximum of 500 ml.

  - *Stable*: IV NS TKO

- Transport to appropriate hospital.

A. <u>Manage Special Considerations</u>

- **Axial Spinal Immobilization**: LALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  D-istracting Injury?

  - Consider maintaining spinal alignment on the gurney, or using axial spinal immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

- ➢ Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization.

NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical. LBB does not need to be reapplied on interfacility transfer (IFT) patients.

- **Fractures**:

  - ➢ **Isolated Extremity Trauma**: Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.

  - ➢ Administer IV NS 250 ml bolus one (1) time.

- **Impaled Object**: Remove object upon Trauma base hospital physician order, if indicated.

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

  - ➢ Apply AED and follow the voice prompts.

B. **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

- *Severe Blunt Force Trauma Arrest*: If indicated, transport to the closest receiving hospital.

- *Penetrating Trauma Arrest*: If indicated, transport to the closest receiving hospital.

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

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- **Precautions and Comments**:

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

  - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

  - If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.

  - **Unsafe scene may warrant transport despite low potential for survival.**

  - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders**: May order additional fluid boluses.

IV. ALS INTERVENTIONS

- Advanced Airway (as indicated):

  - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #8120 - Continuation of Care.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* BP <90mmHG and/or signs of inadequate perfusion, start 2nd IV access.

  - *Stable*: BP >90mmHG and/or signs of adequate tissue perfusion.

  Blunt Trauma:

  - *Unstable*: IV NS open until stable or 2000 ml maximum is infused.

  - *Stable*: IV NS TKO

Penetrating Trauma:

- *Unstable*: IV NS 500 ml bolus one (1) time.
- *Stable***:** IV NS TKO

Isolated Closed Head Injury:

- *Unstable:* IV NS 250 ml bolus, may repeat to a maximum of 500 ml
- *Stable*: IV NS TKO

- Transport to appropriate hospital.
- Insert nasogastric/orogastric tube as indicated.

A. <u>Manage Special Considerations</u>

- **Axial Spinal Immobilization**: ALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  Distracting Injury?

  - Consider maintaining spinal alignment on the gurney, or using axial spinal immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.
  - Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization.

  NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization. Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical. LBB does not need to be reapplied on interfacility transfer (IFT) patients.

- **Chest Trauma**: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.

- **Fractures**:

  - **Isolated Extremity Trauma**: Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.

  - **Pain Relief**:
    - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.
    - Consider Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.
    - Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Fentanyl. Administer IV NS 250 ml bolus one (1) time.

- **Head and Neck Trauma**: Immediately prior to intubation, consider prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.

- **Base Hospital Orders**: When considering Nasotracheal intubation ($\geq$ 15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, Trauma base hospital contact is required.

- **Impaled Object**: Remove object upon Trauma base hospital physician order, if indicated.

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

  - Treat per ICEMA Reference #11070 - Cardiac Arrest - Adult.

B. **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

- *Severe Blunt Force Trauma Arrest*: If indicated, pronounce on scene.

- *Penetrating Trauma Arrest*: If indicated, transport to the closest receiving hospital.

- If the patient does not meet the "Obvious Death Criteria" per ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- **Precautions and Comments**:

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

  - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

  - **Unsafe scene may warrant transport despite low potential for survival.**

  - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders**: May order additional medications and/or fluid boluses.

V. REFERENCES

Number	Name
7040	Medication - Standard Orders
8120	Continuation of Care
11070	Cardiac Arrest - Adult
12010	Determination of Death on Scene

TRAUMA - PEDIATRIC
(Less than 15 years of age)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

Inyo and Mono Counties do not have trauma center designations and the assigned base hospital should be contacted for determination of appropriate destination.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patient airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O_2 saturation (if BLS equipped).
- Keep patient warm and reassure.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

A. <u>Manage Special Considerations</u>

- **Axial Spinal Immobilization**: Using age appropriate assessments, if the patient meet(s) any of the following indicators using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  D-istracting Injury?

  - ➢ Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using spine board.

- **Axial Spinal Immobilization with use of a Rigid Spine Board**: If the use of a rigid, spine board is indicated, and the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

- **Abdominal Trauma**: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.

- **Amputations**: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

  Partial amputation: Splint in anatomic position and elevate the extremity.

- **Blunt Chest Trauma**: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.

- **Flail Chest**: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.

- **Fractures**: Immobilize above and below the injury. Apply splint to injury in position found except:

  - **Femur**: Apply traction splint if indicated.

  - **Grossly angulated long bone with distal neurovascular compromise**: Apply gentle unidirectional traction to improve circulation.

  - **Check and document distal pulse before and after positioning**.

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

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

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

  - **Avulsed Tooth**: Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

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

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

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway (as indicated).

  - Unmanageable Airway: Transport to the closest most appropriate receiving hospital when the patient requires an advance airway. An adequate airway cannot be maintained with a BVM device.

- Apply AED.

- IV Access (warm IV fluids when available).

  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.

    Administer 20 ml/kg NS bolus IV. May repeat once.

  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

    <u>Maintain</u> IV NS rate at TKO.

- Transport to appropriate hospital. Pediatric patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closes trauma hospital.

A. Manage Special Considerations

- **Axial Spinal Immobilization**: LALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators while considering age-appropriate assessments when using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  D-istracting Injury?

  - Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

  - Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.

- **Axial Spinal Immobilization with use of a Rigid Spine Board**: If the use of a rigid, spine board is indicated, and the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

- **Fractures**

  - **Isolated Extremity Trauma**: Trauma <u>without multisystem mechanism</u>. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.

  - Administer IV NS 250 ml bolus one (1) time.

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

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

  - Apply AED and follow the instructions.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

  - *Severe Blunt Force Trauma Arrest*: If indicated, transport to the closest receiving hospital.

  - *Penetrating Trauma Arrest*: If indicated, transport to the closest receiving hospital.

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

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base hospital contact.

- **Precautions and Comments**:

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

  - Confirm low blood sugar in children and treat as indicated with altered level of consciousness.

  - Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.

  - **Unsafe scene may warrant transport despite low potential for survival**.

  - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders**: May order additional fluid boluses.

IV. ALS INTERVENTIONS

- Advanced airway (as indicated).

  - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then**

transport to the closest receiving hospital and follow ICEMA Reference #8100 - Continuation of Trauma Care.

- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).

  - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.

    Administer 20 ml/kg NS bolus IV/IO, may repeat once.

  - *Stable*: Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

    Maintain IV NS rate at TKO.

- Transport to Trauma Center: Pediatric patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closest trauma hospital.

- Insert nasogastric/orogastric tube as indicated

A. Manage Special Considerations

- **Axial Spinal Immobilization**: ALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators while considering age-appropriate assessments when using the acronym (NSAID):

  N-euro Deficit(s) present?
  S-pinal Tenderness present?
  A-ltered Mental Status?
  I-ntoxication?
  D-istracting Injury?

  - Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

  - Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.

- **Axial Spinal Immobilization with use of a Rigid Spine Board**: If the use of a rigid, spine board is indicated, and the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

- **Blunt Chest Trauma**: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.

- **Fractures**

  - **Isolated Extremity Trauma**: Trauma <u>without multisystem mechanism</u>. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured - e.g. dislocated shoulder, hip fracture or dislocation.

  - **Pain Relief**:
    - Fentanyl per ICEMA Reference #7040 - Medication - Standard Orders.
    - For patients four (4) years old and older, consider Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.
    - Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Fentanyl. Administer 20 ml/kg NS bolus IV/IO one time.

- **Head and Neck Trauma**: Immediately prior to intubation, consider prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders for suspected head/brain injury.

- **Base Hospital Orders**: When considering Nasotracheal intubation ($\geq$15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, Trauma base hospital contact is required.

- **Impaled Object**: Remove object upon Trauma base hospital physician order, if indicated.

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

  - Treat per ICEMA Reference #14040 - Cardiac Arrest - Pediatric.

- **Determination of Death on Scene**: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

  - *Severe Blunt Force Trauma Arrest*: If indicated, transport to the closest receiving hospital.

  - *Penetrating Trauma Arrest*: If indicated, transport to the closest receiving hospital.

- If the patient does not meet the "Obvious Death Criteria" in ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- **Precautions and Comments**:

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

  - Confirm low blood sugar in children and treat as indicated with altered level of consciousness.

  - Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.

  - **Unsafe scene may warrant transport despite low potential for survival**.

  - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders**: May order additional medications and/or fluid boluses.

V. REFERENCES

Number	**Name**
7040	Medication - Standard Orders
12010	Determination of Death on Scene
14040	Cardiac Arrest - Pediatric
15030	Trauma Triage Criteria and Destination Policy

TRAUMA TRIAGE CRITERIA

I. PURPOSE

To establish Trauma Triage Criteria that is consistent with the American College of Surgeons standards that will help identify trauma patients in the field, and based upon their injuries, direct their transport to an appropriate Trauma Center (TC).

II. POLICY

A. Trauma Triage Criteria

Measure vitals and Level of Consciousness (LOC).

A patient shall be transported to the closest Trauma Center (TC) if any one physiologic criteria is present following a traumatic event. Trauma base hospital contact shall be made.

1. Physiologic Indicators:

- **Glasgow Coma Scale (GCS)/**
  - Adult and Pediatric
    - GCS $\leq$ 13
- **Respiratory**
  - Adult and Pediatric
    - RR < 10 or > 29
    - (RR < 20 for infant < 1 year old) or need for ventilatory support
- **Hypotension**
  - Adult
    - BP < 90 mmHG
    - tachycardia
  - Pediatric
    - exhibits inadequate tissue perfusion
    - abnormal vital signs (according to age)

2. Anatomic Indicators:

- **Penetrating injuries to head, neck, torso and extremities proximal to the knee or elbow**

- **Blunt chest trauma resulting in chest wall instability or deformity (e.g., flail chest or ecchymosis)**

- **Two (2) or more proximal long bone fractures (femur, humerus)**

- **Crushed, degloved, mangled or pulseless extremity**

- **Amputation proximal to the wrist or ankle**

- **Pelvic fractures**

- **Open or depressed skull fracture**

- **Paralysis**

A patient shall be transported to the closest TC if any one (1) anatomic criteria is present following a traumatic event. Trauma base hospital contact shall be made.

If physiologic or anatomic criteria is not met, assess mechanism of injury and evidence of high-energy impact.

3. Mechanism of Injury:

- **Falls**

  - Adults: > 20 feet (one story is equal to 10 feet)
  - Pediatric: > 10 feet or two (2) to three (3) times the child's height

- **High-risk auto crash**

  - Intrusion, including roof: > 12 inches occupant site
  - Ejection (partial or complete) from automobile
  - Death in the same passenger compartment
  - Vehicle telemetry data consistent with a high-risk injury

- **Auto versus pedestrian/bicyclist thrown, run over, or with significant (> 20 mph) impact**

- **Motorcycle crash > 20 mph**

If a patient has one or more of the following mechanisms of injury **with** any of the above physiologic or anatomic criteria transport to the closest TC.

If there are no associated physiologic or anatomic criteria meets one or more of the following mechanisms of injury, contact a Trauma base hospital for physician consultation to determine the patient destination. In some cases, a Trauma base hospital may direct a patient a non-trauma receiving hospital.

4. Age and Co-Morbid Factors

Assess special patient or system considerations.

If the patient does not meet any of the above criteria, make Trauma base hospital contact to determine if a TC should be the destination for the following patients:

- **Older adults > 65 years of age**

  - Risk of Injury/death increases after age 65
  - SBP < 110 might represent shock after age 65
  - Low impact mechanism (e.g., ground level falls might result in severe injury

- **Children**

  - Should be triaged preferentially to pediatric capable trauma centers
  - Pediatric patients will be transported to a Pediatric Trauma Center when there is less than a 20 minute difference in transport time to the Pediatric Trauma Center versus the closest TC

- **Anti-coagulants and bleeding disorders**

  - Patients are at high risk for rapid deterioration

- **Burns (Refer to ICEMA Reference #8030 - Burn Criteria Destination Policy)**
  - Without other trauma mechanism triage to closest receiving hospital or burn center.
  - With trauma mechanism, triage to TC. Make Trauma base hospital contact.
- **Pregnancy >20 weeks**
- **EMS Provider Judgement**

C. <u>Exceptions</u>

The patient meets Trauma Triage Criteria, but presents with the following:

- **Unmanageable Airway**:
  - If an adequate airway cannot be maintained with a BVM device and the paramedic (EMT-P) is unable to indicate or if indicated, perform a successful needle cricothyrotomy:
    - Transport to the closest receiving hospital. RSI should be performed in a hospital setting and not on scene
    - Refer to ICEMA Reference #8120 - Continuation of Care for rapid transport to the nearest TC
- **Severe Blunt Force Trauma Arrest**:
  - Refer to ICEMA Reference #12010 - Determination of Death on Scene.
    - Severe blunt force trauma, pulseless, without signs of life and cardiac electrical activity less than 40 bpm)
    - If indicated, pronounce on scene
  - If patient does not meet determination of death criteria, transport to closest receiving hospital.
- **Penetrating Trauma Arrest:**
  - Refer to ICEMA Reference #12010 - Determination of Death on Scene.
    - If the patient does not meet the *"Obvious Death Criteria"* in the ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented

asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

- If indicated, transport to the closest receiving hospital.

- **Burn Patients**:

  - Refer to ICEMA Reference #8030 - Burn Criteria and Destination Policy.

  - Burn patients meeting Trauma Triage Criteria, **transport to the closest TC.**

  - Burn patients not meeting Trauma Triage Criteria, **transport to the closest receiving hospital or a Burn Center.**

- **EMS Aircraft Indications**:

  If EMS aircraft is dispatched, adherence to ICEMA Reference #8070 - Aircraft Rotation Policy (San Bernardino County Only) is mandatory.

  - <u>An EMS aircraft may be dispatched for the following events</u>:
    - MCI
    - Prolonged extrication time (> 20 minutes)
    - **Do Not Delay Patient Transport** waiting for an en route EMS aircraft
    - **Utilize the hospital as the landing zone or rendezvous point**

- **EMS Aircraft Transport Contraindications**:

  - <u>The following are contraindications for EMS aircraft patient transportation</u>:
    - Patients contaminated with Hazardous Material who cannot be decontaminated and who pose a risk to the safe operations of the EMS aircraft and crew
    - Violent patients with psychiatric behavioral problems and uncooperative patients under the influence of alcohol and/or mind altering substances who may interfere with the safe operations of an EMS aircraft during flight
    - Stable patients

- Ground transport is < 30 minutes
- Traumatic cardiac arrest
- Other safety conditions as determined by pilot and/or crew

- **Remote Locations**:

  - Remote locations may be exempted from specific criteria upon written permission from the ICEMA Medical Director.

D. Considerations

- Scene time should be limited to 10 minutes under normal circumstances.

E. Radio Contact

- If not contacted at scene, the receiving TC must be notified as soon as possible in order to activate the trauma team.

- Patients meeting all Trauma Triage Criteria (physiologic, anatomic, mechanism of injury, and/or age and co-morbid factors), a Trauma base hospital shall be contacted in the event of patient refusal of assessment, care and/or transportation.

- In Inyo and Mono Counties, the assigned base hospital should be contacted for consultation and destination.

F. Hospital Trauma Diversion Status

Refer to ICEMA Reference #8060 - San Bernardino County Hospital Diversion Policy.

G. Multi-Casualty Incident

Refer to ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident Policy.

III. REFERENCES

Number	Name
5050	Medical Response to a Multi-Casualty Incident Policy
8030	Burn Criteria and Destination Policy
8060	San Bernardino County Hospital Diversion Policy
8070	Aircraft Rotation Policy (San Bernardino County Only)
12010	Determination of Death on Scene

GLASGOW COMA SCALE
OPERATIONAL DEFINITIONS

EYE OPENING

Spontaneous: Eye opening is spontaneous if the patient's eyes are already open at the time of the assessment with no stimulation other than that of the existing ambient environment. The patient can close his eyes to command. This eye opening response implies an intact reticular activating mechanism and a functioning arousal mechanism.

To Voice: If the patient's eyes are not open at the time of the assessment, a response to voice is present if the eyes open when the patient's name is spoken or shouted.

To Pain: If verbal stimulation is unsuccessful in eliciting eye opening, a response to pain is present if the eyes open when a standard pain stimulus is applied.

None: No eye response is present if the above attempts at stimulation are unsuccessful.

BEST VERBAL RESPONSE

Oriented: After being aroused, the patient is asked name, place and date. The patient is oriented if the answers given are correct.

Confused: The patient is confused if the individual cannot answer the questions regarding, name, place and date accurately, but is still capable of producing phrases, sentences or conversation exchanges.

Inappropriate: In this state, the patient cannot produce phrases, sentences or conversational exchanges, but can produce an intact word or two. These words may be electable only in response to physical stimulation and may frequently be obscenities or relative's names.

Incomprehensible: In this state, the patient can produce groans, moans or unintelligible mumblings, but cannot produce an intact word in response to stimulation.

None: In this state, the patient does not respond with any phonation to any stimulation no matter how prolonged or repeated.

BEST MOTOR RESPONSE

Obedient: In response to instructions, whether verbal or written, or through gestures, patient shows ability to comprehend the instruction and to physically execute it. A common example is the command to hold up two fingers.

Purposeful: When a standard painful stimulus is applied, the patient may move limb or body away from stimulus in a purposeful manner or attempt to push stimulus away.

Withdrawal: If the patient does not obey commands, the standard pain stimulus is applied. Withdrawal is present if 1) the elbow flexes, 2) the movement is rapid, 3) there is no muscle stiffness and 4) the arm is drawn away from the trunk.

Flexion: Flexion is present if 1) the elbow flexes, 2) the movement is slow, 3) muscle stiffness is present, 4) the forearm and hand are held against the body and 5) the limbs hold a hemiplegic position.

Extension: Extension is present if 1) the legs and arms extend, 2) muscle stiffness is present and 3) external rotation of the shoulder and forearm occurs.

None: Maximum standard pain stimulation produces no motor response.

NOTE: Spinal cord injury may invalidate motor assessment in this form.

Modified Glasgow Coma Scale for Infants and Children

	Child	Infant	Score
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain only	To pain only	2
	No response	No response	1
Best verbal response	Oriented, appropriate	Coos and babbles	5
	Confused	Irritable cries	4
	Inappropriate words	Cries to pain	3
	Incomprehensible sounds	Moans to pain	2
	No response	No response	1
Best motor response*	Obeys commands	Moves spontaneously and purposefully	6
	Localizes painful stimulus	Withdraws to touch	5
	Withdraws in response to pain	Withdraws to response in pain	4
	Flexion in response to pain	Abnormal flexion posture to pain	3
	Extension in response to pain	Abnormal extension posture to pain	2
	No response	No response	1

* If patient is intubated, unconscious, or preverbal, the most important part of this scale is motor response. Motor response should be carefully evaluated.

HOSPITAL EMERGENCY RESPONSE TEAM (HERT) POLICY

I. PURPOSE

To establish a formal mechanism for providing rapid advanced surgical care at the scene, in which a higher level of on scene surgical expertise, physician field response, is requested by the on scene emergency medical services (EMS) provider.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1798 (a)

III. DEFINITIONS

Hospital Emergency Response Team (HERT): Organized group of healthcare providers from a designated Level I or II Trauma Center, with local emergency medical services agency (LEMSA) approval as a HERT provider, who are available 24 hours/day, 7 days/week (24/7) to respond and provide a higher level of on scene surgical expertise.

Incident Commander (IC): Designated officer with overall responsibility for the management of the incident.

IV. PRINCIPLES

A. In general, a HERT is utilized in a situation where a **life-saving** procedure, such as an amputation, is required due to the **inability to extricate** a patient. Life before limb concept is utilized as a life-saving measure, not as a time saving measure.

B. HERT should be assembled and <u>ready to respond within twenty (20) minutes</u> of a request with standard life-saving equipment in accordance with the HERT provider's internal policy on file with ICEMA.

C. The standard life-saving equipment referenced above shall be predetermined, preassembled, readily available, clearly labeled, and stored in a predetermined location. Based upon the magnitude and nature of the incident, the standard life-saving equipment may require augmentation.

V. POLICY

A. <u>Composition of a HERT</u>

1. The composition of the HERT, and the identification of a Physician Team Leader, shall be in accordance with the approved HERT provider's internal policy on file with ICEMA.

2. The Physician Team Leader:

   a. Is responsible for organizing, supervising, and accompanying members of the team to a scene where a physician field response has been requested.

   b. Shall be familiar with base hospital operations and the ICEMA's policies, procedures, and protocols.

   c. Is responsible for retrieving the life-saving equipment and determining if augmentation is required based upon the magnitude and nature of the incident.

   d. Will determine the ultimate size and composition of the team based upon the magnitude and nature of the incident.

   e. Will report to, and be under the authority of, the IC or their designee. Other members of the team will be directed by the Physician Team Leader.

B. Activation of a HERT

1. The anticipated duration of the incident should be considered in determining the need for a HERT. Before requesting a HERT, the IC should take into account that it may be a minimum of thirty (30) minutes before a team can be on scene.

2. The IC shall contact the appropriate communications center and request the HERT.

3. San Bernardino County Communication Center shall contact the approved HERT provider regarding the request. The Physician Team Leader will organize the team and equipment in accordance with the HERT provider's internal policy, and the magnitude and nature of the incident.

4. The IC will provide pertinent information regarding the incident through their communications center.

5. The Physician Team Leader shall inform the San Bernardino County Communication Center once the team has been assembled and indicate the number of team members.

6. San Bernardino County Communication Center will notify the IC of the estimated time of arrival and mode of transportation of the HERT.

7. Consider secondary air ambulance for patient transportation.

C. Transportation of a HERT

1. When either ground or air transportation is indicated, the San Bernardino County Communication Center will arrange emergency response vehicle transportation for the HERT.

2. Consider use of larger ground (CCT or bariatic) or air units for transport of patient and the HERT to a receiving hospital.

3. Upon the conclusion of the incident, the HERT will work with the IC to contact the San Bernardino County Communication Center to arrange transportation of the team back to the originating facility, if needed.

D. Responsibilities of a HERT On Scene

1. Upon arrival of the HERT, the Physician Team Leader will report directly to the IC. Access to the emergency medical scene will be at the discretion of the IC. The HERT members will have the recommended safety gear:

   - Safety goggles
   - Leather gloves
   - ANSI approved rescue helmet with HERT labeled on both sides (blue)
   - Nomex jumpsuit with HERT indicated on the back (blue)
   - DOT safety vests
   - ANSI/NFPA approved safety boot with steel toe and steel shank

   Only personnel that meet the minimum safety gear requirements may be allowed into the area. All other responding personnel will be kept at a safe distance.

2. Documentation of care rendered will be completed on hospital approved trauma flow sheets (nursing notes) and physician progress notes.

E. Approval Process of a HERT

Trauma Centers interested in providing a HERT must develop internal policies to comply with all requirements and submit evidence of the ability to meet all requirements of this policy to ICEMA for review and approval as a HERT provider.