

## Imperial County Emergency Medical Services Policy, Procedure & Protocol Manual

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**QUALITY ASSURANCE / CONTINUOUS QUALITY IMPROVEMENT  
RESPONSIBILITIES - GENERAL GUIDELINES**

Authority: Division 2.5, Chapter 4 of the Health and Safety Code  
Title 22, Division 9 of the California Code of Regulations

1. The EMS Agency shall establish and facilitate a system wide quality assurance and continuous quality improvement program to monitor, review, evaluate and improve the delivery of prehospital care services.
  - 1.1 The program shall involve all system participants and shall include, but not be limited to the following activities:
    - 1.1.1 Prospective - designed to prevent potential problems.
    - 1.1.2 Concurrent - designed to identify problems or potential problems during the course of patient care.
    - 1.1.3 Retrospective - designed to identify potential or known problems and prevent their recurrence.
    - 1.1.4 Reporting/Feedback - quality assurance incidents should be reported to the EMS Agency in accordance with Policy #1200 and utilizing the approved Incident Report Form (Policy #1210).
2. Each ALS/LALS service provider shall submit a Quality Assurance / Continuous Quality Improvement plan, developed in accordance with this policy, to the EMS Agency for approval.

**QUALITY ASSURANCE RESPONSIBILITIES – EMS AGENCY**

1. Prospective
  - 1.1 Comply with all pertinent rules, regulations, laws and codes of Federal, State and County applicable to emergency medical services.
  - 1.2 Establish / coordinate EMS Quality Assurance Committee.
  - 1.3 Plan, implement and evaluate the emergency medical services system including public and private agreements and operational procedures.
  - 1.4 Implement advanced life support and limited advanced life support systems.

- 1.5 Approve and monitor prehospital training programs.
  - 1.6 Certify / authorize prehospital personnel.
  - 1.7 Establish policies and procedures to assure medical control, which may include dispatch, basic life support, advanced life support, patient destination, patient care guidelines and quality assurance requirements.
  - 1.8 Facilitate, as needed, the implementation of quality assurance plans by system participants.
  - 1.9 Establish procedures for implementing the Certification Review Process for EMS personnel.
  - 1.10 Establish procedures for implementing the Incident Review Process.
2. Concurrent
    - 2.1 On call availability for unusual occurrences, including but not limited to:
      - 2.1.1 Mass Casualty Incidents (MCIs) that tax local medical and health resources
      - 2.1.2 Disasters (natural and man-made)
      - 2.1.3 Suspected Bioterrorism Incidents
3. Retrospective
    - 3.1 Monitor and evaluate the quality of prehospital care.
    - 3.2 Evaluate the process developed and implemented by system participants for retrospective analysis of prehospital care.
4. Reporting/Feed-back
    - 4.1 Evaluate incident reports submitted by system participants and make changes in system design as necessary.
    - 4.2 Provide feedback to system participants when applicable or when requested on Quality Assurance issues.

- 4.3 Design prehospital research and efficacy studies regarding the prehospital use of any drug, device or treatment procedure where applicable.

## **QUALITY ASSURANCE RESPONSIBILITIES – FIRST RESPONDERS (BLS)**

1. Prospective
  - 1.1 Participation on EMS quality assurance committees.
  - 1.2 Education
    - 1.2.1 Orientation to EMS system.
    - 1.2.2 Continuing Education activities to further the knowledge base of the field personnel.
    - 1.2.3 Participation in continuing education courses and the training of prehospital care providers.
    - 1.2.4 Establish procedure for informing all field personnel of system changes.
    - 1.2.5\* Establish procedure for conducting skills proficiency demonstration sessions.
  - 1.3 Evaluation - Develop criteria for evaluation of field personnel to include, but not limited to:
    - 1.3.1 Patient Care Report Form or other documentation if available
    - 1.3.2 Ride-along
    - 1.3.3 Evaluation of new employees
    - 1.3.4 Routine
    - 1.3.5 Problem-oriented
    - 1.3.6 Design standardized corrective action plans for individual first responder deficiencies.
  - 1.4 Certification - establish procedures based on Imperial County policies to ensure:
    - 1.4.1 Initial certification/accreditation
    - 1.4.2 Recertification/reaccreditation
    - 1.4.3\* Attendance at skills proficiency demonstration sessions.
    - 1.4.4\* Mechanisms for personnel to make up missed skills proficiency demonstration sessions.

2. Concurrent Activities

- 2.1 Ride-along - Establish a procedure for evaluation of first responders utilizing performance standards through direct observation

\* Applies only to authorized departments who utilize personnel trained and certified to perform the following skills:

- AED
- Combitube intubation

3. Retrospective Analysis

- 3.1 Develop a process for retrospective analysis of field care, utilizing the Patient Care Report Form or other available documentation (if applicable), to include but not limited to:

3.1.1 High-risk, low frequency interventions

3.1.2 Problem-oriented calls

3.1.3 Those calls requested to be reviewed by the EMS Agency or Base Hospital.

3.1.4 Specific audit topics established through the Quality Assurance Committee.

- 3.2 Develop performance standards for evaluating the quality of care delivered by field personnel through retrospective analysis.

- 3.3 Participate in the Incident Review Process in accordance with local policies.

- 3.4 Participate in prehospital research and efficacy studies requested by the EMS Agency and/or the Quality Assurance Committee.

4. Reporting/Feedback

- 4.1 Develop a process for identifying trends in the quality of field care.

4.1.1 Design and participate in educational activities based on problem identification and/or trend analysis.

4.1.2 Make approved changes in internal policies and procedures based on problem identification and/or trend analysis.

## **QUALITY ASSURANCE RESPONSIBILITIES – ALS/LALS PROVIDER AGENCIES**

1. Prospective
  - 1.1 Participation on EMS quality assurance committees.
  - 1.2 Education
    - 1.2.1 Orientation to EMS system
    - 1.2.2 Field Care Audits
    - 1.2.3 Participate in certification courses and the training of prehospital care providers.
    - 1.2.4 Offer educational programs based on problem identification and trend analysis.
    - 1.2.5 Establish procedure for informing all field personnel of system changes
  - 1.3 Evaluation - Develop criteria for evaluation of individual ALS/LALS personnel to include, but not limited to:
    - 1.3.1 PCR review / tape review or other documentation as available
    - 1.3.2 Ride-along
    - 1.3.3 Evaluation of new employees
    - 1.3.4 Routine
    - 1.3.5 Problem-oriented
    - 1.3.6 Design standardized corrective action plans for individual personnel deficiencies
  - 1.4 Certification/Accreditation - establish procedures based on Imperial County policies regarding:
    - 1.4.1 Initial certification/accreditation
    - 1.4.2 Recertification/Continuing Accreditation
    - 1.4.3 Continuing Education
    - 1.4.4 Other training as specified by the EMS Agency.
2. Concurrent Activities
  - 2.1 Ride-along - Establish a procedure for evaluation of ALS/LALS personnel utilizing performance standards through direct observation
  - 2.2 Provide availability of Field Supervisors and/or Quality Assurance Liaison personnel for consultation/assistance.

3. Retrospective Analysis

3.1 Develop a process for retrospective analysis of field care, utilizing Patient Care Reports and audio tape (if applicable), to include but not limited to:

3.1.1 High-risk, low frequency interventions

3.1.2 Problem-oriented calls

3.1.3 Those calls requested to be reviewed by the EMS Agency or Base Hospital.

3.1.4 Specific audit topics established through the Quality Assurance Committee.

3.2 Develop performance standards for evaluating the quality of care delivered by field personnel through retrospective analysis.

3.3 Participate in the Incident Review Process in accordance with local policies.

3.4 Participate in prehospital research and efficacy studies requested by the EMS Agency and/or the Quality Assurance Committee.

4. Reporting/Feedback

4.1 Develop a process for identifying trends in the quality of field care.

4.1.1 Design and participate in educational activities based on problem identification and/or trend analysis.

4.1.2 Make approved changes in internal policies and procedures based on problem identification and/or trend analysis.

## **QUALITY ASSURANCE RESPONSIBILITIES - BASE HOSPITAL**

### **1. Prospective**

- 1.1 Participation on the Quality Assurance Committee.
- 1.2 Education
  - 1.2.1 Field Care Audits
  - 1.2.2 Continuing Education activities that are consistent with regulations (Title 22, Chapter 2, 3 and 4).
  - 1.2.3 Offer educational programs based on problem identification and/or trend analysis.
  - 1.2.4 Participation in the training of prehospital care providers.
  - 1.2.5 Establish criteria for offering supervised clinical experience to ALS/LALS personnel.
- 1.3 Evaluation - Develop criteria to evaluate the Base Hospital Physicians (BHPs) and Mobile Intensive Care Nurses (MICNs) to include, but not limited to:
  - 1.3.1 Evaluation of new employees
  - 1.3.2 Routine calls – tape and written record
  - 1.3.3 Problem oriented calls
  - 1.3.4 Design standardized corrective action plans for individual BHP and MICN deficiencies.
- 1.4 Orientation/Education - establish procedures for BHPs and MICNs regarding:
  - 1.4.1 Initial orientation
  - 1.4.2 Continuing education
- 1.5 Develop criteria for and designate a Base Hospital Coordinator (BHC) to serve as prehospital liaison, and Base Hospital Medical Director (BHMD) in accordance with Title 22.

### **2. Concurrent Activities**

- 2.1 Provide on-line medical control for ALS/LALS personnel within the Imperial County approved scope of practice.
- 2.2 Develop a procedure for identifying problem calls.

- 2.3 Develop internal policies regarding BHP / MICN involvement in medical control according to Imperial County policies and procedures.
- 2.4 Develop a procedure for obtaining patient follow-up on all Base Hospital directed calls.
- 2.5 Develop performance standards for evaluating the quality of on-line medical control delivered by the BHPs and MICNs through direct observation by the BHC / BHMD.
- 2.6 Participate in the evaluation of field personnel through ride-along in conjunction with the provider agencies.

### **3. Retrospective analysis**

- 3.1 Develop a process for retrospective analysis of field care and base direction utilizing the call record, audiotape, PCR and patient follow-up, to include but not limited to:
  - 3.1.1 high-risk, low frequency interventions
  - 3.1.2 problem-oriented calls
  - 3.1.3 calls requested to be reviewed by the EMS Agency or other EMS Provider
  - 3.1.4 specific topics established through the Quality Assurance Committee.
- 3.2 Establish a procedure for ensuring that patient follow-up has been obtained from the receiving hospital on all patients where base contact was made.
- 3.3 Develop performance standards for evaluating the quality of medical direction delivered by the MICNs / BHPs through retrospective analysis.
- 3.4 Evaluate medical care delivered by prehospital care providers based on performance standards through retrospective analysis.
- 3.5 Participate in prehospital research and efficacy studies requested by the EMS Agency or the Quality Assurance Committee.

### **4. Reporting/Feed-back**


- 4.1 Develop a process for identifying problems and/or trends in the quality of medical direction delivered by MICNs / BHPs.
  - 4.1.1 Design and participate in educational activities based on problem identification and/or trend analysis.
  - 4.1.2 Make approved changes in internal policies and procedures based on problem identification and/or trend analysis.
- 4.2 Participate in the process of identifying problems and/or trends in the quality

of care delivered by field personnel.

- 4.3 Develop / maintain a hospital diversion log and submit monthly to the EMS Agency.

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**APPROVAL**

  
Bruce E. Haynes, M.D.  
EMS Medical Director

# IMPERIAL COUNTY INTUBATION DATA COLLECTION FORM

This form must be completed on all Endotracheal Intubation Attempts

*(SEND FORM TO BASE HOSPITAL)*

GENERAL INFORMATION			
Date:	Unit #	Intubator:	Run #
Age/Sex	Type of Arrest <input type="checkbox"/> Traumatic <input type="checkbox"/> Witnessed <input type="checkbox"/> Cardiac <input type="checkbox"/> Non-witnessed <input type="checkbox"/> Respiratory		Down Time:
Trauma Pt? <input type="checkbox"/> YES <input type="checkbox"/> NO	Head Trauma? <input type="checkbox"/> YES <input type="checkbox"/> NO	Immediate CPR on scene: <input type="checkbox"/> Yes <input type="checkbox"/> No	
AIRWAY PRIOR TO INTUBATION			
<input type="checkbox"/> None <input type="checkbox"/> Bag-Valve Mask	<input type="checkbox"/> Oral <input type="checkbox"/> Nasal	<input type="checkbox"/> Combitube <input type="checkbox"/> other	
INTUBATION PROCEDURE			
# Of Intubation Attempts:  <i>(Count all airway interruptions)</i>	Placement $\checkmark$ d: <input type="checkbox"/> Co2 Cap <input type="checkbox"/> Ausc. & Chest movement <input type="checkbox"/> Toomey		Type of Blade Used and Size <input type="checkbox"/> Straight _____ <input type="checkbox"/> Curved _____
COMPLICATIONS OR SIGNIFICANT CIRCUMSTANCES			
<input type="checkbox"/> Vomitus <input type="checkbox"/> Blood	<input type="checkbox"/> Positioning <input type="checkbox"/> (+) gag reflex	<input type="checkbox"/> unable to intubate: _____ <input type="checkbox"/> other: _____	
Receiving Hospital	VITAL SIGNS UPON ARRIVAL		
<input type="checkbox"/> ECRMC <input type="checkbox"/> PMH <input type="checkbox"/> JFK <input type="checkbox"/> other	Pulse: Respiration: B/P:	ECG: O2 Sat:	
Patient Outcome: <input type="checkbox"/> Expired <input type="checkbox"/> Admitted <input type="checkbox"/> Transferred			
↓TO BE COMPLETED BY RECEIVING PHYSICIAN↓			
Was ETT properly <b>POSITIONED</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was ETT properly <b>SECURED</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physician Signature:			
Comments:			

Addressograph

**IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES AGENCY**

**TRIAL STUDY DATA FORM  
COMBITUBE AIRWAY**

Incident Date: \_\_\_\_\_  
First Responder Agency: \_\_\_\_\_  
Transport Agency & Unit: \_\_\_\_\_  
Receiving Hospital: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_

**COMBITUBE INTUBATION ATTEMPTS**

Attempted by	Number of Attempts	Successful
_____	_____	YES or NO
_____	_____	YES or NO

Tube placement:            ESOPHAGUS            TRACHEA  
Placement confirmed by:    Lung Sounds            Toomey Syringe            Both

Please describe any problems encountered with combitube intubation:

Report filed by: \_\_\_\_\_

Signature: \_\_\_\_\_

IMPERIAL COUNTY EMS AGENCY  
TCP SUPPLEMENTAL INFORMATION SHEET

Date _____	Time _____	RUN # _____
EMT-P Name (print) _____		
Additional Crew Name _____		
Provider Agency _____		

PATIENT INFORMATION		
Age: _____	Sex: _____	Weight: _____ lbs
Rhythm upon arrival: _____		
Estimated time of onset of symptoms: _____		
LOC Upon Arrival (GCS): _____		
Vitals Upon Arrival: Pulse: _____	BP: _____	
Time of Arrival: _____		
Time of Initial Pacing: _____		
Initial Rate of Pacing: _____		
Maximum Amperage: _____		
Maximum Rate: _____		
Electrical Capture:	YES	NO
Mechanical Capture:	YES	NO
Pulse: _____	BP: _____	
LOC After Pacing (GCS): _____		
List any complications from TCP: _____		

THE FOLLOWING TO BE COMPLETED BY BASE HOSPITAL COORDINATOR

EMERGENCY DEPARTMENT DISPOSITION			
Receiving Hospital: _____			
Admitted to hospital?	YES	NO	ICU or M/S
Coroner Case?	YES	NO	
Survival to Discharge?	YES	NO	

Base Hospital Coordinator: \_\_\_\_\_  
Signature
Date

**IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES AGENCY**  
Automatic External Defibrillation (AED) Report Form

The following to be completed by AED crew:			
INCIDENT DATE:	UNIT #:	AGENCY:	
PATIENT NAME:		AGE:	SEX:
WITNESSED ARREST <input type="checkbox"/> YES <input type="checkbox"/> NO		BYSTANDER CPR <input type="checkbox"/> YES <input type="checkbox"/> NO	
AED OPERATOR:		Please Print	
OTHER CREW MEMBER NAME:		Cert #:	
		Cert #:	
ESTIMATED TIME OF COLLAPSE		hrs	
DISPATCH TIME		hrs	
ARRIVED ON SCENE		hrs	
PATIENT CONTACT TIME		hrs	
TIME OF FIRST DEFIBRILLATION		hrs	
ALS ARRIVAL TIME		hrs	
TRANSPORT PROVIDER:			
RECEIVING HOSPITAL:			
SIGNATURE OF AED OPERATOR:			DATE:
Attach completed report to PCR and submit to EMS Agency Download memory module or attach printout			
The following to be completed by EMS Coordinator			
INITIAL RHYTHM:		SHOCK DELIVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID PATIENT CONVERT TO SHOCKABLE RHYTHM?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
NUMBER SHOCKS DELIVERED:		FINAL RHYTHM:	
RETURN OF PULSE: <input type="checkbox"/> YES <input type="checkbox"/> NO		D.O.S. <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOSPITAL DISPOSITION: <input type="checkbox"/> EXPIRED <input type="checkbox"/> ADMITTED <input type="checkbox"/> RELEASED			
COMMENTS:			
<b>ACTION</b>			
<input type="checkbox"/> Commendation		<input type="checkbox"/> Case Review	
<input type="checkbox"/> Recommend education/training		<input type="checkbox"/> No further action needed	
EMS COORDINATOR:			
DATE COMPLETED:			
The following to be completed by agency AED coordinator			
<b>ACTION</b>			
<input type="checkbox"/> Commendation		<input type="checkbox"/> Education/training	
<input type="checkbox"/> No further action needed			
SIGNATURE OF AED COORDINATOR:			
DATE COMPLETED & FILED:			

Authority: Health & Safety Code, Division 2.5; California Code of Regulations, Title 22;  
Evidence Code 1157

**1. INCIDENT NOTIFICATION:**

- 1.1 Any agency or individual may submit an Incident Report Form. Only one form needs to be submitted for a given incident.
- 1.2 Submit the form to the EMS Agency via mail, fax, e-mail, or by hand. Mark the envelope, fax or e-mail as "CONFIDENTIAL".

**2. INVESTIGATION AND FOLLOW-UP**

- 2.1 In all cases, the EMS Agency is responsible for coordinating the investigation and follow-up. In most cases, Quality Improvement investigations will be assigned to the Base Hospital Coordinator and conducted in cooperation with QI personnel of the involved agencies.
- 2.2 After an initial review, EMS will determine the need for further action to include:
  - 2.2.1 Commendation
  - 2.2.2 Remedial training
  - 2.2.3 Certification Review Process
  - 2.2.4 Policy/Procedure/Protocol revision
  - 2.2.5 Further investigation warranted
  - 2.2.6 No further action needed

**3. DOCUMENTATION**

An Incident Report Form shall be initiated for all incident reports and completed in accordance with Policy #1210.

**4. DISCOVERY**

The prohibition relating to discovery or testimony provided in Section 1157 shall be applicable to proceedings and records of any committee established by the EMS Agency (see Evidence Code 1157.7).

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

ADMINISTRATION

**INCIDENT REPORT FORM**

**POLICY # 1210**

**This section to be completed by individual initiating Incident Report.**

Incident Date/Time:	Base Hospital Run #:
Report Initiated By:	Agency:
Reason for Initiating Incident Report:	
<input type="checkbox"/> Treatment / action resulting in positive patient outcome <input type="checkbox"/> Treatment / action resulting in or having potential for adverse patient outcome <input type="checkbox"/> Policy / Procedure / Protocol issue <input type="checkbox"/> Other (explain):	
Comments (attach additional pages as necessary):	
<b>Attach copy of PCR and submit report to EMS Agency</b>	

**This section to be completed by Investigator**

CHECKLIST

<input type="checkbox"/> Review PCR, MICN report & tape <input type="checkbox"/> Collect statements from personnel involved in incident <input type="checkbox"/> Collect statements from other personnel as needed	
Investigator (Signature)	Date
<b>Attach all documents and return to EMS Agency</b>	

**EMS AGENCY REVIEW**

ACTION

<input type="checkbox"/> Award Commendation <input type="checkbox"/> Revise Policy/Procedure/Protocol <input type="checkbox"/> Conduct remedial training <input type="checkbox"/> Initiate Certification Review Process <input type="checkbox"/> No further action necessary <input type="checkbox"/> Other (explain):	
Reviewed by (Signature)	Date

Authority: Health & Safety Code, Division 2.5; California Code of Regulations, Title 22

The designation of a hospital as a Base Hospital for purposes of the Emergency Medical Services System of the County of Imperial confers upon the facility the recognition that it has the commitment, personnel, and resources necessary to provide optimum medical care for the emergency patient. Contractor shall meet or exceed the criteria set forth herein and demonstrate a continuous ability and commitment to comply with policies, procedures, and protocols developed by the Emergency Medical Services Agency.

A Designated Base Hospital shall meet the requirements of Title 22, Division 9 of the California Code of Regulations. In addition:

I. Base Hospital Shall:

- A. Appoint a Base Hospital Medical Director and a Base Hospital Nurse Coordinator with adequate secretarial support. Time commitments for fulfilling these roles must be assured by the institution.
- B. Provide continuing education seminars for EMS pre-hospital personnel and MICN's in sufficient amount to meet recertification requirements.
- C. Agree to regard EMT-P, EMT-II, EMT-1 tapes as part of the patient's medical record and maintain them in accordance with regulations governing medical records.
- D. Agree to maintain and make available to Imperial County EMS all relevant pre-hospital records and evaluation of the advanced life support system.
- E. Conduct audits of ALS and BLS transports such that Physician/MICN/EMT-P/EMT-II/EMT-1 have the opportunity to assess their strengths and weakness regarding patient care and transports.
- F. Permit periodic announced and unannounced site surveys of its facilities by the EMS Agency, or its designated representatives, for the purpose of monitoring contract compliance, including but not limited to reviewing logs and medical records of patients who received BLS/ALS pre-hospital care.

II. Base Hospital Medical Director:

- A. A physician, licensed in the State of California, who regularly works in the Emergency Department.

- B. Have experience in emergency medical care.
  - C. Have experience in and knowledge of base hospital radio operations and Imperial county EMS policies and procedures.
  - D. Shall be responsible for:
    - 1. Medical control and on-line supervision of the EMT-P, EMT-II, EMT-1 Program within the base hospital's service area.
      - a. Review Emergency Medical Services personnel (Base Hospital Physicians, MICNs, EMT-Ps, EMT-IIs EMT-1's) compliance to policies, procedures, and protocols in the pre-hospital setting as well as their demonstration of skills retention in performing those activities.
      - b. Evaluate care given by personnel in the pre-hospital setting.
    - 2. Implementing and maintaining a Quality Assurance Program which includes audit process, issue identification and analysis, corrective action plan and implementation, evaluation and follow-up.
    - 3. Reporting deficiencies in patient care management to the EMS Agency in accordance with local policies and procedures approved by the EMS Medical Director.
    - 4. Maintaining regular communications and serving as liaison between the receiving hospitals and the base hospital in order to review treatment given to patients utilizing the Emergency Medical Services System in the Base Hospital's service area.
    - 5. Orientation of new Base Hospital Emergency Department Physicians with respect to pre-hospital emergency care and EMS policies and procedures.
- III. Base Hospital Emergency Department Physicians:
- A. Must be familiar with the approved treatment, triage and transfer policies, procedures, protocols, the standards of care established for the area, the level of training and scope of practice of pre-hospital personnel, and BLS

and ALS units' armamentarium; including communications equipment, rescue equipment, drugs, solutions and other supplies.

- B. Must be qualified by knowledge and experience to provide medical directions and management of pre-hospital personnel in compliance with policies, procedures, and protocols approved by the EMS Agency.
- C. Must have working knowledge of the operational aspects of the Base Hospital's communications equipment.

IV. Base Hospital Nurse Coordinator:

- A. Shall be currently certified MICN in Imperial County.
- B. Shall serve as the liaison between the subject Base Hospital and the EMT-P, EMT-II, EMT-1, fire departments, BLS provider agencies, and receiving hospitals operating within the service area. Such liaison functions shall also extend to EMT training agencies, and all components and subcomponents of the Imperial County Emergency Medical Services System.
- C. Shall have thorough understanding of Emergency Medical Services policies, procedures, protocols and pre-hospital care system.
- D. Shall provide sufficient continuing education opportunities for EMT-P, EMT II, EMT-1, and MICN's to assist in their fulfilling the Continuing Education requirements of the State and Local Emergency Medical Services Authority.
- E. Shall assist the Base Hospital Medical Director in the medical control and supervision of EMT-P's, EMT-II's, EMT-1's, and MICN's.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

ADMINISTRATION

**Base Hospital Designation**

**POLICY #1310**

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- I. Authority: Health and Safety code, Sections 1797 and 1798.
- II. Purpose: To establish Imperial County policy for approval and designation as a Base Hospital.
- III. Policy:
  - A. To be designated as an EMT-P, EMT-II, EMT-1 Base Hospital in Imperial County, the requesting institution must:
    1. Comply with California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100174, Chapter 3, Section 100127 and Chapter 2, Section 100064.
    2. Comply with Imperial County Base Hospital Standards (see Policy 1300).
    3. Enter into an Agreement with the Imperial County Public Health Department, Emergency Medical Services Agency to perform as a Base Hospital.
  - B. The Imperial County Public Health Department, Emergency Medical Services Agency shall review its Agreement with each Base Hospital every two (2) years. The Agreement may be changed, renewed, canceled, or otherwise modified when necessary according to provisions for such in the Agreement.
  - C. The Imperial County Public Health Department, Emergency Medical Services Agency may deny, suspend, or revoke the approval of a Base Hospital for failure to comply with applicable policies, procedures, protocols, or regulations in accordance with provisions for such in the Agreement.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

ADMINISTRATION

**CERTIFICATION REVIEW PROCESS**

**POLICY #1400**

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Authority: Any proceedings by the EMS Agency to deny, suspend or revoke the certification of an EMT-I, EMT-II or MICN, or place any EMT-I, EMT-II or MICN certificate holder on probation pursuant to Section 1798.200 of the Health and Safety Code shall be conducted in accordance with California Code of Regulations, Title 22, Division 9, Chapter 6.

I. EMT-I/EMT-II/MICN

Negative action against any prehospital emergency medical certificate/authorization may be instituted by the EMS Medical Director based upon the evidence of a threat to the public health and safety as evidenced by the occurrence of any of the items listed in the Health and Safety Code, Division 2.5, Section 1798.200 or the California Code of Regulations, Title 13, Division 2, Chapter 5, Section 1101.

EMT-I and EMT-II personnel subject to Title 22 Certification Disciplinary Action regulations shall have requests for discovery, petitions to compel discovery, evidence and affidavits consistent with the Administrative Procedures Act (Government Code, Title 2, Division 3, Chapter 5, Sections 11507.6, 11507.7, 11513 and 11514).

II. EMERGENCY MEDICAL TECHNICIAN - PARAMEDIC (EMT-P) – 1798.200, 201, 202

A. The EMS Medical Director may institute the following proceedings against an EMT-P licensee when there exists evidence of a threat to the public health and safety:

1. Referral to State EMS Authority for further action
2. Temporary Suspension of an EMT-P license

B. Referral to the State EMS Authority for potential negative action against an EMT-P license, with or without temporary suspension of an EMT-P license, may be instituted by the EMS Medical Director based upon the finding of a threat to the public health and safety as evidenced by the occurrence of any of the actions in California Health and Safety Code section 1798.200.

III. BASE HOSPITAL OR PROVIDER AGENCY REPORTING OF INCIDENTS

Any incident involving EMS personnel, which may constitute a threat to the public health and safety, should be reported to the Imperial County EMS Agency. When such incidents come to the attention of base hospital or provider agency administrative personnel, a report to the EMS Agency should be made by the Base Hospital Medical Director or Base Hospital Nurse Coordinator, or provider agency administrative personnel, no later than the next business day following the incident or discovery of the incident. If this report is made by telephone, a written report should be submitted within 72 hours.

A. Grounds for reporting include reasonable suspicion of:

1. Functioning outside the scope of practice of the held certificate/authorization.
2. Functioning independent of medical control as described in County policies, procedures and field treatment guidelines.
3. Gross negligence.
4. Repeated negligent acts.

ADMINISTRATION

**CERTIFICATION REVIEW PROCESS**

**POLICY #1400**

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5. Incompetence.
6. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.
7. Violating or attempting to violate directly or indirectly, any provision of the Health and Safety Code or of State regulations pertaining to prehospital personnel.
8. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.
9. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

If, in the judgment of the Base Hospital Medical Director or other Base Hospital physician if the Medical Director is unavailable, immediate action must be taken by the EMS Agency after normal business hours to protect the public health and safety, the EMS Manager may be contacted by pager at (760) 370-9913.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

ADMINISTRATION

**Patient Care Record (Completion & Distribution)**

**POLICY #1500**

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**Authority:** Division 2.5, Chapter 4, Health & Safety Code  
Title 22, California Code of Regulations, Division 9, Chapter 4, Section 100169  
and Section 100170

**I. Purpose**

The California Code of Regulations Title 22, Section 100169 (a) (6) specifies that the Medical Director of the Local EMS Agency shall establish the requirements for the initiation, completion, distribution, review, evaluation and retention of a patient care record (PCR). The PCR is the permanent legal medical record that documents all aspects of prehospital care or refusal of care.

**II. Mandatory Charting & Distribution**

**Electronic PCRs**

An electronic PCR shall be completed as follows:

Transport Providers (EMT-I, EMT-II, Paramedics) shall complete a PCR:

- On every EMS response (to include 911 and interfacility transports) to include “Dry Runs” (no patient contact) and for patients who refuse care and/or transportation.

ALS/LALS First Responder Providers (non-transport) shall complete a PCR:

- when first responders administer advanced interventions prior to the arrival of the transport provider, or
- when first responders cancel the transport provider prior to arrival at the scene for coroner cases or for patients who refuse care and/or transportation.

BLS First Responder Providers (non-transport) do not complete an electronic PCR but may complete a paper PCR.

All sections of the PCR will be filled out with appropriate information. A separate PCR must be completed for every patient contact.

All transport providers in the county and ALS/LALS first responders shall utilize the Imperial County EMS (ICEMS) electronic PCR data reporting system (Web PCR). In the event of system outage when the Web PCR program is not accessible, or if a provider is experiencing significant user problems for a prolonged period of time (greater than 12 hours), providers may utilize paper PCRs until the system is restored and functioning properly.

Providers utilizing Web PCR data system shall sign into the secure system with their user name and password. User name, date, and time on printed, faxed or downloaded PCRs constitutes an electronic signature.

Patient Care Records will be promptly completed following each call. Electronic PCRs may be completed at designated workstations at each receiving facility with a printed copy left with the

attending nurse/physician.

If PCR's are not left at the receiving hospital at the completion of the call, PCR's will be completed at an authorized work site no later than 12 hours after completion of the call with a copy faxed to the receiving facility under a "Confidential" cover sheet. (See attachment for instructions for utilizing designated workstations at receiving hospitals and for faxing PCR's to receiving facilities). The receiving facility will incorporate the PCR into the patient's medical record.

Coroner Cases – complete a paper PCR while on scene and give the middle (yellow) copy to the Deputy Coroner or to a law enforcement officer if EMS personnel are unable to wait on scene for the arrival of the Deputy Coroner. If EMS personnel are unable to complete PCR while on scene, a copy must be faxed to the ICSD Coroner's Department as soon as possible.

DNR Cases – complete a paper PCR for specific DNR cases that require signature from physician or family member on the PCR in accordance with Policy #4150.

### **Paper PCR's**

In the event that paper PCR's are utilized, three (3) copies of the PCR will be distributed as follows:

- Original (white) to the provider agency
- One copy (yellow) to receiving hospital or to Deputy Coroner
- One copy (pink) to Base Hospital (Base Coordinator will forward this copy in a timely manner to the EMS Agency after completing CQI audit)

### **III. Continuous Quality Improvement**

In accordance with Policy #1100, the Base Hospital, designated provider QA Coordinators, and EMS Agency will conduct PCR audits to verify completion and distribution of PCR's in accordance with this policy. The criterion is that PCR's will be promptly completed and appropriately distributed 100% of the time.

### **IV. Disciplinary Actions**

Disciplinary action may be taken by the EMS Medical Director for failure to comply with this policy. Disciplinary actions may involve remediation, probation or any proceedings to suspend or revoke the certification/license of an EMT-I, EMT-II or paramedic pursuant to Section 1798.200 of the Health and Safety Code.

ADMINISTRATION

**Patient Care Record (Completion & Distribution)**

**POLICY #1500**

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

## **Guidelines for Completing Web PCRs from Hospital Emergency Departments**

### **El Centro Regional Medical Center**

Procedure for accessing Imperial County WebPCR from ECRMC ED:

You may use computer EDNET3 (the one closest to the printer in station 3)

Steps:

1. Find the Imperial County WebPCR icon located on the screen.
2. Double click the icon
3. Select option Production (Live) Database and double click
4. Insert username and pass code
5. Our printer will automatically print out 2 copies. Please give one copy to the unit secretary.

This is the only computer to be used for pre-hospital providers. Please do not use any other computer. If the computer is unavailable (i.e., currently being used by staff), then we ask that you complete your PCR at your quarters and fax a copy to (760) 339-7342 when it is completed.

### **Pioneers Memorial Hospital**

Listed below are instructions on how to get access to Imperial County Web PCR from the designated computer at PMH ED:

You may use the two computers located near the back entrance of the ED

1. Universal log in code: PARAMED
2. To log in, click on Start and then to "log on or off" (this will get you started)
3. You will see the login Network

- Login Name: PARAMED (hit Tab)
- Login Password: PARAMED (hit ENTER)

4. This will bring you to the window with the icon name Imperial County Web PCR. From here you will have to login with your own name and password.

If the designated computer in the ED is in use, you will need to complete the PCR back in quarters. Please fax the completed PCR to 351-3137.

**IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES**

**PATIENT CARE REPORT FORM  
INSTRUCTION MANUAL**

Revised 08/99

## INTRODUCTION

This instruction booklet is intended to assist you in correctly utilizing the County's Patient Care Report (PCR) Form. Correct and complete documentation of the care and services you provide is vital to the patient, the agency providing care, the receiving hospital, and the EMS Agency.

## BACKGROUND

State regulation requires that each EMS system collect and evaluate certain data on the activities of the system. EMS provider agencies need data to evaluate their response times, equipment utilization, and the quality of prehospital care provided by agency personnel. Physicians and nurses need to know how the patient presented in the field, what care you administered and how the patient responded to these interventions. You need to have accurate and complete records maintained on your actions in the field in the event of future investigation or court proceedings.

## COMPLETING THE FORM

### When to complete a Patient Care Report Form:

A **Transport Provider** should complete a PCR whenever they respond (that is, whenever their unit leaves the station) to an emergency medical aid call. A PCR should also be completed for each non-emergency patient transport to include local interfacility and out-of-county transfers.

It is necessary to complete this form even when the call is later cancelled as your agency's emergency resources are utilized. Documentation for a cancelled call should include the date, dispatch address, unit # and agency, the time the call was received and when your unit was enroute. Then mark the box **[X]** indicating this was a **CANCELLED** call and the name of the agency that cancelled you. Include your license/certification number and signature.

In situations where there are more than one patient, one form is to be completed for each patient. However, in mass casualty/disaster situations, it is not necessary to utilize the PCR forms. In these situations, the County's multi-casualty "Triage Report Form" (attached) will be kept as a record of prehospital activities. A copy of the completed "Triage Report Form" must be submitted to the Base Hospital Coordinator or EMS Agency.

**First Responders** need only complete this form when any of the advanced interventions are used, the patient is released or a determination of death is made **prior to arrival of the transport provider**. To avoid duplication, First Responders **do not** have to complete a PCR if treatment is administered in the presence of the Transport Provider (as long as both First Responder and Transport Provider are the same level or the Transport Provider is a higher level of care provider). Advanced interventions include utilizing the semi-automatic defibrillator by an EMT-D to treat a shockable rhythm, and any of the advanced skills and medications administered by an Advanced EMT, EMT-II, or Paramedic.

First responders may choose to complete this form on scene while waiting arrival of the transport provider or they may complete the form upon returning to quarters. If they complete the form on scene, they should give the yellow copy to the transport provider to be delivered with the patient to the receiving hospital. If the PCR is not completed until the first responder is back in quarters, then the yellow copy should be mailed or faxed to the receiving hospital as soon as possible.

## **DISTRIBUTION OF PCR COPIES**

The top, **white** copy (original) is to be kept by the service provider. This copy is often used for billing purposes and for "in-house" quality assurance in addition to being your agency's legal record of the call.

The **yellow**, middle copy is to be delivered with the patient to the receiving hospital and will become a part of the patient's permanent medical record. The yellow copy may also be given to the coroner in the event a determination of death is made on scene.

The **pink**, bottom copy is for QA (Quality Assurance) and CQI (Continuous Quality Improvement). If the patient is delivered to the Base Hospital, this copy should be placed in the appropriate receptacle near the Base Station radio. If the patient is delivered to another hospital, this copy(s) should be mailed or faxed to the Base Hospital Coordinator daily if possible, but no more than on a weekly basis.

## **DETAILED INSTRUCTIONS**

The information to be recorded on the PCR is of various types; some is hand written, some require a mark **[X]** to be made in the space provided, and some require you to circle the correct information. Whichever type it is, **please press hard** to make your entries legible on the pink copy. If you make an error in any of your selections, please line out the wrong choice and then mark and initial the correct one. If you have made several errors, please start with a new form.

**Beginning at the top left corner of the form:**

**DATE** - the date of the incident.

**ENCOUNTER OR DISPATCH ADDRESS** - the address where the patient(s) was found. This address may be different from the location you were dispatched to. If so, you may want to record both the encounter and dispatch address. This may justify any delays in response times. The dispatch address will be recorded if no patient contact was made or if this was a cancelled call.

**PATIENT INFORMATION** - record the patient's name, address, health insurance, phone number, Social Security Number, age, sex, weight, date of birth, illnesses, medications, allergies, and primary physician.

Then complete the information to indicate your agency's Incident Number, your 4-digit Unit ID Number, Agency name, the time the Call was Received, time you were Enroute, time you Arrived on Scene, time you Departed Scene, time you Arrived at your Destination (this refers to the time the transport provider arrived at the receiving facility), and the time you were Ready for another call. If you did not transport a patient, then your time for departing the scene would most often be the same time you are ready for another call.

**PATIENT ASSESSMENT** - Begin by filling in the patient's STATUS (mild, moderate, or severe) followed by the CHIEF COMPLAINT or MECHANISM OF INJURY. Then, use the NARRATIVE section to give pertinent details about the history of the problem. Important details would include events or complaints that preceded the onset of symptoms, details about the accident to include speed, type of accident (rollover, head-on, etc.), extent of damage to vehicle(s), what restraints or protection were used (seat belts, air bag, child seat, helmet, etc.), and if the patient was ejected or extricated. Findings from the PQRST, BRIM, APGAR, or other special assessments should also be documented in this section.

**MAJOR TRAUMA** - the EMS Agency will occasionally need to gather information on specific areas of the EMS system in order to perform a more thorough evaluation of that area. The Agency is presently doing a study on the overall system response to major trauma patients. Please mark this box  if the patient sustained serious injury(s) that either cause or have the potential to cause disability or death. We are particularly interested in patients with trauma to the head or trunk who require surgical intervention to stabilize their condition, or patients who need to be admitted to the ICU. This box should also be marked based on the mechanism of injury even if serious injury(s) are not yet apparent.

**PHYSICAL EXAM** - Document any abnormalities you have detected during the physical exam or mark the box  indicating the findings were "unremarkable".

**INITIAL VITALS** - document your initial findings for the patient's pulse, respirations, blood pressure, EKG and glucometer (if indicated). These will serve as the "base line" vitals.

**LUNG SOUNDS** - circle the letter **L** or **R** to indicate the lung sounds for both the left and right lungs.

**SKINS** - write in the patient's skin color, temperature, and moisture.

**PUPILS** - circle the letter **L** or **R** to indicate your findings for each pupil.

**GLASGOW COMA SCALE** - the coma scale is most often used for trauma patients and patients with an altered level of consciousness. Circle the response to each category (MOTOR, VERBAL, EYE), add the points and then write the GCS Total in the space provided. The repeat coma score (if performed) should be documented in the PATIENT RESPONSE/UPDATE section.

**TREATMENT PRIOR TO ARRIVAL** - mark all boxes indicating the treatment given prior to your arrival and identify the agency administering the care. Document the IV solution and all drugs given in the spaces provided.

**PATIENT CARE** - This section is used to document any treatment (procedures and medications) administered by the provider. The care giver's initials and the time should be documented for each treatment modality. The "Patient Response/Update" section should include statements of changes in the patient's condition following each treatment modality as well as an updated set of vitals and EKG (if indicated). A useful tool for evaluating pain or respiratory distress is the 1-10 analog scale. By using the scale, the patient's pain or distress level can be documented upon the initial assessment and also following each treatment modality directed at relieving the symptoms. A recording of the initial EKG and any pertinent rhythm changes should be attached to the yellow (receiving hospital) copy of the PCR. If possible, attach copies of the rhythm strips to the pink copy of the PCR as well to be used for educational reviews.

If any medications or IVs are administered, chart the **time** they were administered, the **dose** or **amount** that was given, the **route** (SQ, IM, IV, ET, SL, PO, Topically or Rectally), the **site** where an IV was established and/or where a medication was injected, and for IVs - the **rate** at which it was given.

If a patient required **endotracheal or Combitube intubation**, document each care giver's initials who attempted intubation, the number of attempts made, whether or not you were successful, the size ETT or Combitube used, and bilateral breath sounds after intubation.

**PATIENT DISPOSITION** - This section begins with identifying the agency that assumed responsibility for patient care from you and the time care was transferred. The transfer of care would occur when an ambulance team takes over patient care from a first responder, or when one ambulance meets with and turns over patient care to another ambulance, or when an air team (helicopter) takes over patient care from a first responder or ground ambulance crew.

Below this section, indicate by marking the appropriate box **[X]** if the patient was transported, released, DOS (Dead On Scene), no patient contact was made, or if you were cancelled prior to arriving on scene. If the patient is determined to be dead on scene, the PCR should be completed as soon as possible with the yellow copy distributed to the deputy coroner.

In the second column enter the name of the **RECEIVING FACILITY** and the patient's **MEDICAL RECORD #**. The medical record number is especially important for retrieving documents at a later time for the county-wide quality assurance and continuous quality improvement (QACQI) program.

Then enter the **REASON FOR SELECTION** of the receiving hospital. Options include the patient be transported to the **nearest** facility appropriate to the needs of the patient, or **diversion** to an alternate facility (most often occurs because the nearest or most appropriate facility was not able to receive patients at that time), or because of a **request** from a physician, patient, or guardian that the patient be transported to other than the nearest facility.

In the third column enter the **BASE HOSPITAL RUN #** and the name of the **BASE HOSPITAL MD OR MICN** who provided on-line medical control. Directly below the Base Hospital section is a box to mark if treatment was administered utilizing the County **COMMUNICATION FAILURE PROTOCOL**. The "Communication Failure Report Form" must also be completed and attached to the PCR and submitted to the Base Hospital Coordinator within 24 hours.

Enter the **RESPONSE** and **TRANSPORT CODE** in the last column by circling either **2** (non-emergency) or **3** (emergency) for each category. **Please do not use Code-1 as it is not recognized by the EMS database.**

The **license or certification number** and **signature** of the individuals primary involved with rendering patient care must be entered to complete the form.

Try to limit your documentation to the spaces provided. However, if you feel you need to document more information than the spaces allow in the narrative section, attach an additional PCR (labeled page 2). **Please do not use the "Patient Care" section to continue your "Narrative" history.**

## **RELEASE FROM CARE**

On the back of the top, white copy of the PCR is a patient release form to be completed whenever a patient or guardian refuses further care and/or transportation. The patient refusing medical care must be competent and over 18 years old, an emancipated minor, a minor who is married, a minor who is in the military, a legal guardian or the parent of the minor. Refer to the county policy regarding patient refusal for further requirements.

## **IMPERIAL COUNTY EMS "TRIAGE REPORT FORM"**

The Triage Report Form (attached) should be utilized whenever EMS personnel respond to a mass casualty incident. Individual PCR's do not need to be completed for each victim. The Triage Report Form should be delivered to the Base Hospital as soon as possible after the event has been mitigated. The Base Hospital should compare the field triage report form with the hospital radio report form to ensure accountability of all victims transported from the scene. (This task will be much easier if hospital is using same triage report form as field providers). The Base Hospital shall send a copy of the Triage Report Form to the EMS Agency.

Any questions regarding this instruction manual or the Patient Care Report Form should be directed to the EMS Agency at 339-4468.

# IMPERIAL COUNTY EMS PATIENT CARE REPORT

DATE		ENCOUNTER OR DISPATCH ADDRESS								
PATIENT INFORMATION										
NAME					SSN	AGE	SEX	WEIGHT	DOB	
ADDRESS					ILLNESSES					
CITY			STATE	ZIP	MEDS					
INSURANCE			TELEPHONE		ALLERGIES			PHYSICIAN		
INCIDENT #	UNIT #	AGENCY		CALL REC'D	ENROUTE	ARV. SCN.	DPT. SCN.	ARV. DEST.	READY	

PATIENT ASSESSMENT							
PATIENT STATUS <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE			CHIEF COMPLAINT / MECHANISM OF INJURY		<input type="checkbox"/> MAJOR TRAUMA		
NARRATIVE:     							
UNREMARKABLE HEAD / FACE <input type="checkbox"/> NECK <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/>			UNREMARKABLE PELVIS / GROIN <input type="checkbox"/> ARMS / HANDS <input type="checkbox"/> LEGS / FEET <input type="checkbox"/> BACK <input type="checkbox"/>				
INITIAL VITALS	LUNG SOUNDS	SKINS	PUPILS	GLASGOW COMA SCALE			
PULSE	L R CLEAR	COLOR	L R PERL	MOTOR		VERBAL	EYE
RESP	L R WHEEZES	TEMPERATURE	L R PINPOINT	6 OBEYS	5 ORIENTED	4 SPONTANEOUS	
B/P	L R RALES		L R DILATED	5 LOCALIZES	4 CONFUSED	3 VOICE	
EKG	L R DIMINISHED	MOISTURE	L R UNEQUAL	4 WITHDRAWAL	3 INAPPROPRIATE	2 PAIN	
GLUCOMETER	L R ABSENT		L R FIXED	3 FLEXION	2 INCOMPREHENSIBLE	1 NONE	
	L R OTHER:		L R CATARACTS	2 EXTENSION	1 NONE	<b>GCS TOTAL =</b>	
			L R OTHER	1 NONE			

TREATMENT PRIOR TO ARRIVAL			
<input type="checkbox"/> BYSTANDER CPR	AGENCY ADMINISTERING CARE: _____		<input type="checkbox"/> DRUGS: _____
<input type="checkbox"/> CLEAR AIRWAY	<input type="checkbox"/> VENTILATIONS	<input type="checkbox"/> OXYGEN	<input type="checkbox"/> INTUBATION <input type="checkbox"/> IV: _____
<input type="checkbox"/> CPR	<input type="checkbox"/> SPLINT / BANDAGE	<input type="checkbox"/> IMMOBILIZE SPINE	<input type="checkbox"/> COUNTERSHOCK

PATIENT CARE									
CARE GIVER	TIME	PROCEDURE - MEDICATION		PATIENT RESPONSE / UPDATE		PULSE	RESP	B/P	EKG
<b>ETT</b>	Care Giver #1:	Time:	Attempts:	<input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful	Size ETT:	Breath Sounds: Right    Left:			
	Care Giver #2:	Time:	Attempts:	<input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful	Size ETT:	Breath Sounds: Right    Left:			
<b>INTUBATION</b>	Care Giver #1:	Time:	Attempts:	<input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful	Size ETT:	Breath Sounds: Right    Left:			

PATIENT DISPOSITION					
CARE TRANSFERRED TO:		RECEIVING HOSPITAL:	BH RUN #:		RESPONSE CODE    2    3
AGENCY:	TIME:	MEDICAL RECORD #:	BH MD / MICN:		TRANSPORT CODE    2    3
<input type="checkbox"/> PATIENT TRANSPORTED <input type="checkbox"/> DOS <input type="checkbox"/> RELEASED <input type="checkbox"/> NO PATIENT CONTACT <input type="checkbox"/> CANCELLED BY:		REASON FOR SELECTION <input type="checkbox"/> NEAREST <input type="checkbox"/> REQUEST BY MD, <input type="checkbox"/> DIVERSION    PATIENT, GUARDIAN		COMMUNICATION FAILURE PROTOCOL	LICENSE / CERT#    SIGNATURE

DISTRIBUTION:    WHITE: SERVICE PROVIDER    YELLOW: RECEIVING FACILITY / CORONER    PINK: BASE HOSPITAL / EMSA

**RELEASE FROM CARE  
FORMA DE LIBERACION DE QUIDADO**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian: \_\_\_\_\_

**Check all that apply:**

- Base Hospital contacted.
- Patient (or guardian) has been advised of patient's medical condition.
- Patient (or guardian) advised that the following consequences of refusal may occur:  
\_\_\_\_\_  
\_\_\_\_\_

**STATEMENT**

This is to certify that I am refusing further evaluation, treatment, and/or transport at my own insistence. I have been advised of any potential consequences that may result from not seeking further care or evaluation at this time. I understand that I may call EMS at any time should I decide to seek further attention.

**AFIRMACION**

Esto es para certificar que estoy rechazando asistencia medica y transportacion. Me han informado de la potencia de consecuencias que pueden resultar al no solicitar asistencia medica, o no ser evaluada en este tiempo. Entiendo que puedo llamar a EMS a cualquier tiempo si decido necesitar atencion medica.

I hereby release: \_\_\_\_\_ Ambulance Service

Yo en lo presente \_\_\_\_\_ Fire Department  
pongo en liberacion: \_\_\_\_\_

Other Agency

and the medical control physician at the Base Hospital (ECRMC), their employees and officers from all liability for any adverse problems that may result from my decision.

y el medico de control de medicina en el Base Hospital (ECRMC), sus empleados y oficiales de toda responsabilidad de cualquier problema adverso.

Signature (Patient or Guardian):

\_\_\_\_\_  
Firma (Paciente of Guardian)

Signature (EMT):

\_\_\_\_\_  
Signature (Witness):



EMS PERSONNEL

## EMERGENCY MEDICAL TECHNICIAN (EMT) CERTIFICATION/RE-CERTIFICATION

**POLICY #2100**

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- I. **Authority:** Health and Safety Code, Sections 1797.170, 1795.175 and 1797.210 and California Code of Regulations, Title 22, Division 9, Chapter 2, Article 4, Section 100079-100083.
  
- II. **Purpose:** To establish the requirements for EMT certification/recertification in the County of Imperial.
  
- III. **Policy:**
  - A. To be eligible for certification as an EMT in Imperial County, the candidate must meet the following criteria:
    1. **Initial Certification:**
      - a. Must be 18 years of age or older.
      - b. Must hold a valid EMT Course Completion Record from an approved EMT course.
      - c. Must hold a current EMT National Registry Card.
      - d. Must possess a current CPR Card (Health Care Provider/Professional Rescuer or equivalent).
      - e. Must submit to a California Department of Justice (DOJ) live scan and Federal Bureau of Investigation (FBI) criminal background check (separate from any agency requirement).
      - f. Application for certification must be made within two (2) years of being issued an EMT Course Completion record.
    2. **Recertification:**
      - a. Hold a current EMT Certificate in the State of California.
      - b. Successfully complete an approved refresher course within the two (2) years prior to application for recertification, or
      - c. Complete 24 hours of approved continuing education (CE) within two (2) years prior to application for recertification.
      - d. Present a current CPR Card (Health Care Provider/Professional Rescuer or equivalent).

EMS PERSONNEL

**EMERGENCY MEDICAL TECHNICIAN (EMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2100**

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- e. Submit to a California Department of Justice (DOJ) live scan and Federal Bureau of Investigation (FBI) criminal background check if not yet completed for County of Imperial EMS.
- f. Submit a complete an EMT skills competency verification form.

3. Lapse in Certification:

- a. For a lapse within six months, the individual shall comply with the original requirements for re-certification.
- b. For a lapse of six months or more, but less than twelve months, the individual shall comply with the original requirements for recertification and complete an additional twelve hours of continuing education for a total of 36 hours of training.
- c. For a lapse of twelve months or more, but less than 24 months, the individual shall comply with the original requirements for recertification and complete an additional twenty-four hours of continuing education, for a total 48 hours of training, and present a current National Registry Card.
- d. For a lapse of greater than twenty-four months the individual shall complete an entire EMT course and comply with the original requirements for initial certification.

B. Notification responsibilities:

- 1. The EMT shall be responsible for notifying County of Imperial EMS of her/his proper and current mailing and residential address and shall notify County of Imperial EMS in writing within thirty (30) calendar days of any and all changes of the mailing and residential address, giving both the old and the new address, and California Emergency Medical Services Authority (EMSA) EMT central registry number.

EMS PERSONNEL

**EMERGENCY MEDICAL TECHNICIAN (EMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2100**

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- C. An application for certification or recertification shall be denied without prejudice and does not require an administrative hearing, when an applicant does not meet the requirements for certification or recertification, including but not limited to:
1. Failure to pass certification or recertification examination.
  2. Lack of sufficient continuing education or documentation of a completed refresher course.
  3. Failure to furnish additional information or documents requested by the certifying entity.
  4. Failure to pay any required state and local fees.
- D. The denial shall be in effect until all requirements for certification or recertification are met. If a certificate expires before recertification requirements are met, the certificate shall be deemed a lapsed certificate and subject to the provision pertaining to lapsed certificates.
- E. An individual who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose California EMT certificate expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, may be given an extension of the expiration date of the individual's EMT certificate for up to six (6) months from the date of the individual's EMT certificate upon compliance with the following provisions:
1. Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from duty.
  2. If there is no lapse in certification, meet the requirements for recertification. If there is a lapse, meet the requirements of a lapsed certification.
  3. Provide documentation showing that the CE activities submitted for the certification renewal period were taken not earlier than thirty (30) calendar

EMS PERSONNEL

**EMERGENCY MEDICAL TECHNICIAN (EMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2100**

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days prior to the effective date of the individual's EMT certificate that was valid when the individual was activated for duty and not later than six (6) months from the date of deactivation/release from duty.

4. For an individual whose active duty requires the use of EMT skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS CE Regulations (Division 9, Title 22, California Code of Regulations) while the individual was on active duty. The documentation shall include verification from the individual's Commanding Officer attesting to the classes attended.

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APPROVED:



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Bruce E. Haynes, M.D.

EMS Medical Director

EMS PERSONNEL

**EMT-I Scope of Practice**

**POLICY #2110**

Authority: Health & Safety Code, Division 2.5; California Code of Regulations, Title 22

An EMT-I student or a currently certified EMT-I may:

- During training while under supervision of a physician, registered nurse, physician's assistance, EMT-P, or EMT-II;
- While at the scene of an emergency;
- During transport; or
- During interfacility transfer,

In accordance with Imperial County EMS Policies, Procedures, and Protocols:

1. Perform any activity identified in the California Code of Regulations, Title 22, Division 9, Section 100063 (Scope of Practice of EMT-I)
2. Perform Optional (Advanced) Skills in accordance with Policy #2200, *EMT-I Optional Skill Accreditation*
3. During interfacility transfers, a certified EMT-I may monitor peripheral IV lines including, but not limited to, heplocks, saline locks, Hickmans, and Port-a-Catheters, provided the following conditions are met:
  - A written order signed by the transferring physician is provided to the EMT-I stating that the patient is stable for transportation by an EMT-I ambulance. The order must include the rate of infusion for the IV fluids and the type of solution infusing.
  - No medications can be added to the IV fluids.
- 3.1 The following IV solutions may be monitored by the EMT-I during interfacility transfers:
  - D5/Water
  - D5/NaCl (any concentration up to 0.9%)
  - D5/Lactated Ringers
  - Normal Saline (NaCl)
  - Lactated Ringers
- 3.2 Patients with vascular access lines through shunts or fistulas are not to be transported by EMT-Is
4. During interfacility transfers, a certified EMT-I may monitor patients with the following invasive tubes and other medical adjuncts:
  - 4.1 Nasogastric Tubes (NGT)
  - 4.2 Abdominal Tubes (Gastrostomy tubes, ureterostomy tubes, wound drains, etc.)
  - 4.3 Foley Catheters
  - 4.4 Tracheostomy Tubes

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

EMS Personnel

**EMT OPTIONAL SKILL ACCREDITATION**

**POLICY #2200**

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- I. **Authority:** California Code of Regulations, Title 22, Division 9, Chapter 2, Article 2, Section 100064, Section 100064.1 and California Health & Safety Code, Division 2.5, Chapter 4, Article 1, Section 1797.210 (a), and Chapter 5, Section 1798.
  
- II. **Purpose:** To set forth the criteria for EMT's to be accredited to perform optional advanced skills in Imperial County.
  
- III. **Policy:** To be eligible for accreditation to perform an optional advanced skill, the individual must:
  - A. **Initial Accreditation**
    1. Possess current certification as an EMT in California
    2. Possess a valid optional skill course completion certificate from an approved training program.
    3. Submit a completed application to the EMS Agency.
    4. Upon successfully completing the requirements for optional skill accreditation, an accreditation card shall be issued that specifies the optional skills the EMT is authorized to perform as follows:
      - i. **Module A: Perilaryngeal Airway Adjunct**
      - ii. The issue date shall be the date the applicant completes all requirements for optional skill accreditation. The expiration date shall be the same as the expiration date of the EMT Certification.
  
  - B. **Continuous Accreditation Requirements**
    1. Once issued, optional skill accreditation is renewed by meeting the following requirements:
      - i. Maintain EMT Certification
      - ii. Skills competency demonstrated by direct observation of an actual or simulated patient contact for each optional skill the EMT is authorized to perform. Skills demonstrations shall include a review of the skill(s), medications and conditions for which they can be administered. The

EMS Personnel

**EMT OPTIONAL SKILL ACCREDITATION**

**POLICY #2200**

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interval between skills demonstration sessions shall be every two (2) years from the date of accreditation. An EMT Optional Skills Competency Verification Form must be completed for each 2 years.

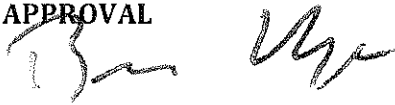
2. Failure to meet the criteria listed in B.1 shall result in suspension of the optional skill accreditation (see Section C for reactivation requirements).

C. Reactivation of a suspended authorization

1. In order to reactivate a suspended optional skill accreditation, an individual must successfully complete the following prior to performing the optional advanced skill:
  - i. Expired EMT: Obtain current certification as an EMT.
  - ii. Lapse in Optional Skill Accreditation of less than one year: Complete the required skills verification form.
  - iii. Lapse in Optional Skill Accreditation of more than one year: Pass an approved optional skill written and practical certifying exam and reapply to the EMS Agency for accreditation.

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**APPROVAL**



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Bruce E. Haynes, M.D.

EMS Medical Director

EMS PERSONNEL

**ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2300**

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- I. **Authority:** Health and Safety Code, Sections 1797.170, 1795.175 and 1797.210, California Code of Regulations Title 22, Chapter 3, sections 100101-100130.
  
- II. **Purpose:** To establish the requirements for Advanced EMT (AEMT) certification/recertification in the County of Imperial.
  
- III. **Policy:**
  - A. To be eligible for certification as an AEMT in Imperial County, the candidate must meet the following criteria:
    1. **Initial Certification:**
      - a. Must be 18 years of age or older.
      - b. Must hold a valid AEMT Course Completion Record from an approved AEMT course.
      - c. Must possess a current CPR Card (Health Care Provider/Professional Rescuer or equivalent).
      - d. Must submit to a California Department of Justice (DOJ) live scan and Federal Bureau of Investigation (FBI) criminal background check if not performed for EMT certification (separate from any agency requirement).
      - e. Complete an AEMT application.
      - f. Application for certification must be made within two (2) years of being issued an AEMT Course Completion record.
      - g. Pay established local and state fee.
      - h. Provide proof of affiliation with an approved AEMT and/or pre-existing EMT-II service provider.
      - i. Successfully complete a precertification field evaluation by a designee of the EMS Medical Director.
      - j. An AEMT shall only be certified by one (1) AEMT certifying entity during a certification period.

EMS PERSONNEL

**ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2300**

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- k. Certification as an AEMT shall be valid for a maximum of two (2) years from the effective date of certification. The expiration date shall be the final day of the month of the two (2) year period.
2. Recertification:
- a. Hold a current AEMT certification in the State of California.
  - b. Complete 36 hours of approved continuing education (CE) within two (2) years prior to application for recertification.
  - c. Present a current CPR Card (Health Care Provider/Professional Rescuer or equivalent).
  - d. Submit to a California Department of Justice (DOJ) live scan and Federal Bureau of Investigation (FBI) criminal background check if not yet completed for County of Imperial EMS.
  - e. Submit a complete AEMT skills competency verification form.
  - f. Complete an Advanced EMT recertification application
  - g. Pay established local and state fee.
  - h. Provide proof of affiliation with an approved AEMT and/or pre-existing EMT-II service provider.
  - i. An AEMT shall only be certified by one (1) AEMT certifying entity during a certification period.
  - j. Certification as an AEMT shall be valid for a maximum of two (2) years from the effective date of certification. The expiration date shall be the final day of the month of the two (2) year period.
3. Lapse in Certification:
- a. For a lapse within six (6) months, the individual shall comply with the original requirements for re-certification.
  - b. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall comply with the original requirements for

EMS PERSONNEL

**ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2300**

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recertification and complete an additional twelve (12) hours of continuing education for a total of forty-eight (48) hours of training.

- c. For a lapse of twelve months or more, but less than twenty-four (24) months, the individual shall comply with the original requirements for recertification and complete an additional twenty-four (24) hours of continuing education, for a total sixty (60) hours of training, and pass the written and skills certification exam.
- d. For a lapse of greater than twenty-four (24) months the individual shall complete an entire Advance EMT course and comply with the original requirements for initial certification.

B. Notification responsibilities:

1. The AEMT shall be responsible for notifying County of Imperial EMS of her/his proper and current mailing and residential address and shall notify County of Imperial EMS in writing within thirty (30) calendar days of any and all changes of the mailing and residential address, giving both the old and the new address, and California Emergency Medical Services Authority (EMSA) AEMT central registry number.

C. An application for certification or recertification shall be denied without prejudice and does not require an administrative hearing, when an applicant does not meet the requirements for certification or recertification, including but not limited to:

1. Failure to pass certification or recertification examination.
2. Lack of sufficient continuing education.
3. Failure to furnish additional information or documents requested by the certifying entity.

EMS PERSONNEL

**ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)  
CERTIFICATION/RE-CERTIFICATION**

**POLICY #2300**

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4. Failure to pay any required fees.
- 
- D. The denial shall be in effect until all requirements for certification or recertification are met. If a certificate expires before recertification requirements are met, the certificate shall be deemed a lapsed certificate and subject to the provision pertaining to lapsed certificates.
  
  - E. An individual who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose California AEMT certificate expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, may be given an extension of the expiration date of the individual's AEMT or EMT-II certificate for up to six (6) months from the date of the individual's AEMT or EMT-II certificate upon compliance with the following provisions:
    1. Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from duty.
    2. If there is no lapse in certification, meet the requirements for recertification. If there is a lapse, meet the requirements of a lapsed certification.
    3. Provide documentation showing that the CE activities submitted for the certification renewal period were taken not earlier than thirty (30) calendar days prior to the effective date of the individual's AEMT or EMT-II certificate that was valid when the individual was activated for duty and not later than six (6) months from the date of deactivation/release from duty.

EMS PERSONNEL

**ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)  
CERTIFICATION/RECERTIFICATION**

**POLICY #2300**

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4. For an individual whose active duty requires the use of AEMT or EMT-II skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS CE Regulations (Division 9, Title 22, California Code of Regulations) while the individual was on active duty. The documentation shall include verification from the individual's Commanding Officer attesting to the classes attended.

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APPROVED:



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Bruce E. Haynes, M.D.

EMS Medical Director

EMS PERSONNEL

**Advanced Emergency Medical Technician (AEMT)  
Scope of Practice**

**POLICY #2310**

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- I. **Authority:** California Code of Regulations, Title 22, Division 9, Chapter 3, Sections 100106-100106.1 and Health and Safety Code, Sections 1797.107, 1797.171.
  
- II. **Purpose:** To establish the scope of practice for Advanced EMT (AEMT) in the County of Imperial.
  
- III. **Policy:**
  - A. An AEMT student or a currently certified AEMT affiliated with an approved AEMT service provider may:
    1. While caring for patients in a hospital or field setting as part of his/her training or continuing education under the direct supervision of a physician, registered nurse, physician assistant, or paramedic; or,
    2. While at the scene of a medical emergency; or,
    3. During transport; or,
    4. During interfacility transfer;
  
  - B. In accordance with Imperial County EMS Policies, Procedures, and Protocols:
    1. Perform any activity identified in the California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100063 (Scope of Practice of an EMT).
  
    2. Perform the following procedures:
      - a. Blood glucose measurement by venous blood/finger stick
      - b. Defibrillation
      - c. Oral intubation with perilaryngeal airway
      - d. Injections (SC/IM)
      - e. Intravenous catheter establishment (peripheral, including external jugular)
      - f. Intravenous medication and solution administration
      - g. Oral medication administration (including sublingual)

EMS PERSONNEL

**Advanced Emergency Medical Technician (AEMT)  
Scope of Practice**

**POLICY #2310**

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- h. Saline lock utilization
3. Administer the following medications:
- a. Albuterol, nebulized
  - b. Activated Charcoal
  - c. Aspirin
  - d. Dextrose 25% and 50%
  - e. Epinephrine (1:1,000 and 1:10,000)
  - f. Glucagon
  - g. Irrigation solutions (sterile water, saline)
  - h. Naloxone
  - i. Nitroglycerine (sublingual tablets or spray)
  - j. Normal Saline
  - k. Oxygen
4. Advanced EMT Local Optional Scope of Practice
- a. Monitor and administer EMT-II medications through preexisting vascular access
  - b. Synchronized cardioversion
  - c. Atropine sulfate
  - d. Lidocaine hydrochloride
  - e. Midazolam
  - f. Morphine sulfate

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APPROVAL



Bruce E. Haynes, M.D.

EMS Medical Director

1. APPLICATION PROCESS

To be considered for accreditation as an EMT -P in Imperial County, a complete application packet shall be submitted to the County EMS Agency. The packet shall include the following:

- Application for Accreditation
- Statement of Eligibility
- California EMT -P License
- California Drivers License
- Application fee

2. ORIENTATION PROCESS

- 2.1 Orientation shall include information and testing on local policies and treatment protocols, radio communications, base and receiving hospitals, and other unique system features. The applicant shall be provided with the information to be tested prior to testing.
- 2.2 Upon submitting an application for accreditation, an EMT -P may begin work immediately in the basic scope of practice. However, until the accreditation process is completed, the EMT -P applicant can only work with a second EMT-P who is already accredited in this county.

3. PRE-ACCREDITATION FIELD EVALUATION

- 3.1 All candidates for accreditation shall complete a field evaluation to determine if the candidate is knowledgeable to begin functioning under local policies and protocols. The field evaluator must be an EMT -P approved by the local EMS agency and must be present with the applicant throughout patient care. A third person must be available to drive an ambulance. The evaluator has the ultimate responsibility for patient care rendered by this EMT -P team. The agency conducting the field evaluation of an EMT -P accreditation applicant must submit a letter accepting such responsibility to the County EMS Agency.
- 3.2 Field evaluations shall be limited to no more than ten (10) ALS calls. This is not to preclude applicants from working in the basic scope of practice as a second EMT -P on a unit during the time when they are not in the pre-accreditation field evaluation.

4. EXPANDED SCOPE OF PRACTICE

- 4.1 Training and testing in any expanded scope of practice skill will focus on local policies, procedures, equipment utilization and other aspects that may differ from another County. The local EMS Agency may choose to delegate this training and testing to other EMS system participants. Testing in the expanded scope of practice may be in written, oral and/or skills format. Repeated training may be required until proficiency is achieved.

EMS PERSONNEL

**EMT-P ACCREDITATION**

**POLICY #2400**

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- 4.2 Training and testing in the expanded scope of practice must be completed within thirty (30) days from receipt of application for accreditation. The provider agency may do the training and testing on any optional scope if time is a factor.

5. ACCREDITATION

- 5.1 Accreditation shall be continuous as long as the EMT -P maintains a valid license, maintains the appropriate level of education and training, and adheres to local medical care standards and protocols.
- 5.2 The Imperial County EMS Agency may waive portions of the accreditation requirements as deemed necessary and appropriate.

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APPROVAL



Bruce E. Haynes, M.D.  
EMS Medical Director

**IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES**

**PARAMEDIC**

**JOHN DOE**

**CA LICENSE #            P-00000**

**IC ACCREDITATION #   00-000**

**ISSUED: 00/00/00**

**APPLICATION  
IMPERIAL COUNTY  
PARAMEDIC ACCREDITATION**

**Full Name:** \_\_\_\_\_  
*LAST FIRST MIDDLE*

**Home Mailing Address:** \_\_\_\_\_  
*STREET APT. NUMBER*

\_\_\_\_\_

*CITY STATE ZIP*

**Home Phone Number:** \_\_\_\_\_

**Paramedic Service Provider Affiliation:** \_\_\_\_\_

**CA EMT-P License #** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Paramedic Training Program:**

<i>NAME OF PROGRAM</i>	
<i>ADDRESS</i>	
<i>CITY</i>	<i>STATE</i>
<i>DATE COURSE COMPLETION</i>	

**List all counties in which you have obtained current or previous accreditation.**

\_\_\_\_\_

**Have you ever had a certification, license, or accreditation denied, suspended, revoked, or put on probation?**

**NO**

**YES**

**If yes, attach a separate sheet of paper describing each occurrence including date(s) and county(s) of occurrence.**

**I hereby affirm that all questions have been answered fully to the best of my knowledge. I realize that any errors or omissions would be grounds for denial or revocation of this application or of my accreditation.**

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

**Attach copy of your current CA EMT-P license, CA driver's license, and a completed statement of Accreditation Eligibility.**

**STATEMENT OF  
AFFILIATION WITH SERVICE PROVIDER**

This form is to be completed by the service provider supervisor. Once completed please fax to the EMS Agency at (760) 482-4519.

\_\_\_\_\_ will be functioning as a \_\_\_\_\_  
(Full Name) (Paid, Volunteer)

\_\_\_\_\_ for this Department. They will be covered by our liability insurance  
(First Responder, EMT-I, II, P, MICN)

while performing these duties. They will be on \_\_\_\_\_  
(Full, Part Time)

status as defined below.

DATE: \_\_\_\_\_

\_\_\_\_\_  
(Authorized Supervisor)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Name of Service Provider)

Full Time:

A. Employed full time, and primary assignment is to the ambulance, rescue squad or emergency department.

Part Time:

A. Employed full time, and primary assignment not always to the ambulance, rescue squad or emergency department; or

B. Employed part time.

## STATEMENT OF CERTIFICATION/ ACCREDITATION ELIGIBILITY

As required by Section 1798.200 of the Health and Safety Code and Title XII California Code of Regulations; all accreditation candidates must read and sign the following:

I \_\_\_\_\_ certify that none of the following statements are true regarding myself, except as noted after my signature:

1. Committed fraud in the procurement of any required certificate.
2. Required under Section 290 of the Penal Code to register as a sex offender for any offence involving force, duress, threat or intimidation.
3. Habitually or excessively uses or is addicted to narcotics or dangerous drugs, or has been convicted during the preceding seven years of any offense relating to the use, sale, possession or transportation of narcotics or addictive or dangerous drugs.
4. Habitually and excessively uses intoxicating beverages.
5. Has been convicted during the proceeding seven years of any offense punishable as a felony and involving force, violence, of any degree during that period. Is on parole or probation for such offenses or crimes involving force, violence, threat, or intimidation.
6. Has committed any act involving moral turpitude, including fraud or intentional dishonesty for personal gain within the preceding seven years.
7. Has demonstrated irrational behavior or incurred a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that his/her ability to perform the duties normally expected of an EMT-P, EMT-II, or EMT-I may be impaired.
8. Commission or conviction of any fraudulent, dishonest or corrupt act which is substantially related to the qualification, functions, and duties of pre-hospital personnel.
9. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of this part or the regulation promulgated by the authority pertaining to pre-hospital personnel.

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Exceptions:

An EMT-P student or a currently certified EMT-P affiliated with an approved EMT-P service provider may:

- While caring for patients in a hospital as part of his/her training or continuing education under the direct supervision of a physician, registered nurse, or physician assistant; or,
- While at the scene of a medical emergency; or,
- During transport; or,
- During interfacility transfer;

In accordance with Imperial County EMS Policies, Procedures, and Protocols:

1. Perform any activity identified in the California Code of Regulations, Division 9, Section 100106 (Scope of Practice of an EMT-II) and Section 100063 (Scope of Practice of an EMT-I).
2. Perform the following procedures:
  - Blood glucose measurement by venous blood/finger stick
  - Continuous Positive Airway Pressure (CPAP)
  - Defibrillation
  - ECG monitoring and dysrhythmia recognition
  - Endotracheal intubation
  - Endotracheal medication administration
  - Oral intubation with Perilaryngeal Airway (King LTD)
  - Injections (SC/IM)
  - Intravenous (peripheral, including external jugular) catheter establishment
  - Intravenous medication and solution administration
  - Intranasal medication administration
  - Laryngoscope use
  - Magill forceps use
  - Monitor thoracostomy tubes
  - Monitor intravenous solutions with potassium  $\leq 40$  mEq/l
  - Monitor and administer EMT-P medications through preexisting vascular access
  - Oral medication administration (including sublingual)
  - Pleural decompression by needle thoracostomy
  - Saline lock utilization
  - Synchronized cardioversion
  - Transcutaneous Pacing (TCP)
  - Tourniquet
  - Valsalva maneuver

EMS PERSONNEL

**EMT-P SCOPE OF PRACTICE**

**POLICY #2410**

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3. Administer the following medications:

- Activated charcoal
- Adenosine
- Albuterol, nebulized
- Aspirin
- Atropine sulfate
- Calcium chloride
- Dextrose 25% and 50%
- Diphenhydramine
- Dopamine hydrochloride
- Epinephrine (1:1,000 and 1:10,000)
- Glucagon
- Irrigation solutions (sterile water, saline)
- Lidocaine hydrochloride
- Midazolam
- Morphine sulfate
- Naloxone
- Nitroglycerine (sublingual tablets or spray)
- Normal Saline
- Ondansetron
- Oxygen
- Sodium Bicarbonate
- Verapamil

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APPROVAL



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Bruce E. Haynes, M.D.  
EMS Medical Director

Authority: Health & Safety Code, Division 2.5; California Code of Regulations, Title 22.

All candidates shall meet the following authorization requirements:

1. Prerequisite Criteria (Documentation that these criteria have been met must be submitted with the candidate's application for authorization):
  - 1.1 Provide evidence of valid and current licensure as a Registered Nurse in California.
  - 1.2 Provide evidence of valid and current ACLS card according to the standards of the American Heart Association.
  - 1.3 Provide evidence of previous authorization as a Mobile Intensive Care Nurse (or Authorized Registered Nurse) in a California county, or  
  
Provide evidence of a minimum of 12 months critical care experience as a Registered Nurse of which at least 6 months must be within the emergency department of an acute care hospital, and  
  
Provide evidence of successful completion of a Mobile Intensive Care Nurse Course approved by the local EMS Agency.
  - 1.4 The candidate will complete an ALS emergency response vehicle observation experience consisting of direct observation of at least 16 hours, which must include at least four (4) ALS patient contacts in which the patient was assessed and treated in the field.
2. Complete the Imperial County MICN Application Packet.
3. Pay all related local MICN authorization and/or testing fee (s).
4. Provide proof of employment as follows:
  - 4.1 Within the emergency department of a designated Base Hospital; OR
  - 4.2 Principal Instructor for the Paramedic Training Program at Imperial Valley College.
5. Upon successful completion of 1- 4 above, the local EMS Agency shall authorize the candidate as a base hospital MICN for a period of four (4) years from the last day of the month in which the certification requirements are met.
6. Candidates failing to successfully complete the authorization process within twelve (12) months from their initial written testing date must repeat the entire authorization process.

Reauthorization: only candidates authorized in Imperial County are eligible for reauthorization. All reauthorization candidates shall meet the following requirements and provide documentation to the EMS Agency:

1. Pay all related local MICN reauthorization and/or testing fee (s), if any.
2. Provide evidence of valid and current licensure as a registered nurse in California.
3. Provide evidence of valid and current American Heart Association ACLS card.
4. Provide proof of having obtained required continuing education approved by the local EMS Agency as follows:
  - 4.1 Attend at least six (6) organized field care case reviews per year. Case review attendance must be documented on the MICN Continuing Education record.
  - 4.2 The completed record, with the Base Hospital Nurse Coordinator signature, must be submitted to the County EMS Agency no later than the last day of each MICN's certification period.
5. Provide proof of employment as follows:
  - 5.1 Assignment within the emergency department of a designated Base Hospital for a minimum of one (1) shift per month for no less than 10 months per calendar year;  
OR
  - 5.2 Primary Instructor for the Paramedic Training Program at IVC; OR
  - 5.3 Base Hospital Nurse Coordinator
6. Upon fulfillment of 1-5 above, the local EMS Agency shall reauthorize the candidate as an MICN for a maximum of four (4) years from the last day of the month in which all recertification requirements were completed.
7. Individuals who have let their MICN authorization lapse shall be eligible for reauthorization when the following have been met:
  - 7.1 A lapse of less than one year: the requirements for reauthorization shall be met and all continuing education missed shall be completed.
  - 7.2 A lapse of between one (1) year and two (2) years: the requirements for reauthorization and the following shall be met:
    - 7.2.1 Complete all continuing education missed
    - 7.2.2 Successfully pass a supervised base hospital evaluation to consist of no less than six (6) ALS patient care radio reports.

EMS PERSONNEL

**MICN AUTHORIZATION**

**POLICY # 2500**

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- 7.3 A lapse of two (2) years or more: the requirements of authorization and additional training/evaluation as required by the medical director of the local EMS Agency.
8. Any exception to the above requirements must be approved by the local EMS Medical Director.

Inactive Status

1. An MICN who does not meet the reauthorization requirements (to include the annual CE, proof of employment and licensing requirements) shall be placed on Inactive Status.
2. When on Inactive Status, the individual will not function as an MICN.
3. To resume active MICN status, the MICN will submit evidence of being current in MICN continuing education requirements as well as complying with all criteria to maintain MICN reauthorization.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

**IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES**

**MOBILE INTENSIVE CARE NURSE**

**JOHN DOE**

**CERTIFICATION #      IC-00-000**

**ISSUED:    0/00/00**

**EXPIRES:  0/00/04**

**Authority:** Health and Safety Code, Division 2.5, Sections 1798; California Code of Regulations Title 22, Chapter 4, Section 100152.

**Purpose:** To assist with the clinical and field internship placement of paramedics enrolled in training programs outside of Imperial County and to enable the quality management of paramedic internships.

**Policy:**

- A. All paramedic students enrolled in out of county training programs, who seek to complete an internship with an Imperial County Advanced Life Support Provider Agency, shall submit the completed Application for Internship Placement form accompanied by the required documentation as well as obtaining an out-of-county intern number for use in the electronic patient care record system:
  1. Proof of completion of didactic portion of an approved paramedic training program.
  2. Proof of five medically supervised intubations during the clinical training.
  3. Application and completion for Local Paramedic Accreditation Orientation and test.
  4. Copy of current ACLS, PALS or PEPP, and ITLS, PHTLS, or ATLS card.
  5. Copy of current AHA Healthcare Provider or other Professional Rescuer CPR card.
  6. Current non-restricted or under investigation EMT certification card.
  
- B. All Out-of-County Paramedic Training Agencies seeking to place students in Imperial County shall contact the Imperial County EMS Agency to notify the potential placement of students in Imperial County.

1. Call the Imperial County EMS Agency (760) 482-4516 to speak with the EMS Agency Manager to verify the availability for internship placement in Imperial County.
2. Supply a fully executed copy of a contract with the provider agency/hospital that will accommodate the paramedic intern. This contract must outline the process for monitoring the paramedic intern as well as the process that will be followed should it be necessary to terminate the internship.
3. List on training agency letterhead, the name(s) of the students(s), the provider agency/hospital that will facilitate the placement of the intern, the name(s) of preceptor(s) and the training agency contact information for all instructors that will be involved with intern(s) placed in Imperial County.

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**APPROVAL**



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Bruce E. Haynes, M.D.  
EMS Medical Director

**AUTHORITY:** Division 2.5 of the Health and Safety Code, Section 1797 and Title 22, Division 9. The approving authority for EMS training programs (other than for a program conducted by a qualified statewide public safety agency) shall be the local EMS agency.

1. The following programs have been approved by the Imperial County EMS Agency:

<u>Program</u>	<u>Standard</u>
• Public Safety First Aid & CPR	Title 22, Div. 9
• First Responder Course	DOT First Responder Curriculum
• Public safety AED	Title 22, Div. 9
• EMT-I (including optional skills)	Title 22, Div. 9
• EMT-Paramedic	Title 22, Div. 9
• Mobile Intensive Care Nurse	Title 22, Div. 9
• Prehospital Continuing Education	Title 22, Div. 9

2. Refer to the appropriate Standard (above) for the specific requirements for these programs.

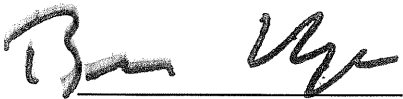
3. New programs being submitted to the EMS Agency for approval must be submitted within the timeframe specified in Title 22 and/or Imperial County EMS policy for program approval. If no specific date is mentioned, the timeframe for approval is 90 days prior to the first course offering.

4. It is the responsibility of all program directors to follow the requirements of the program as described in Title 22 or the appropriate Imperial County Policy.

5. Program renewal is the responsibility of the program director. Renewal applications must be received by the EMS Agency in the timeframe specified in Title 22 or Imperial County Policy. If no specific date is mentioned, program renewal must be submitted 30 days prior to expiration. Any course offered following program expiration will not be considered an approved course.

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**APPROVAL**

  
\_\_\_\_\_  
Bruce E. Haynes, M.D.  
EMS Medical Director

**IMPERIAL COUNTY EMS  
APPLICATION FORM  
EMS TRAINING PROGRAM**

Applications for EMS Training Programs must be submitted with all required documentation to the Imperial County EMS Agency. EMS Training Programs must comply with Imperial County Policy #3000 and Title 22 of the California Code of Regulations for approval.

1. Name/Address of Training Institution:
2. EMS Training Program (to be approved):
3. Program Personnel (attach resumes):
  - a. Program Medical Director:
  - b. Course Director
  - c. Principal Instructors
4. Course Hours:
  - a. Didactic
  - b. Clinical
  - c. Field
  - d. Total
5. Units of Credit (if applicable):
6. Required Materials:
7. Reference Materials:
8. Clinical Preceptors:
9. Field Preceptors:
10. Course Evaluation:

Authority: Health & Safety Code, Division 2.5; California Code of Regulations, Title 22

1. **GENERAL:** Any individual or organization, public or private, interested in providing approved continuing education for prehospital providers shall apply to the local EMS Agency for approval.
2. **APPLICATION PROCESS**
  - 2.1 Interested individuals shall submit an application to the local EMS Agency in accordance with this policy and the "Guidelines for Prehospital Continuing Education" issued by the State EMS Authority (dated Sept. 1994).
  - 2.2 The local EMS Agency shall notify the applicant within fourteen (14) days that the application was received.
  - 2.3 The local EMS Agency shall notify the applicant in writing within sixty (60) calendar days from the receipt of a complete application of its decision to approve or disapprove.
  - 2.4 The local EMS Agency shall issue a "CE Provider Number" to approved applicants in accordance with state regulations and these guidelines.
  - 2.5 Program approval shall be issued for four (4) years. The expiration date shall be four years from the last day of the month in which the application is approved.
3. **CE PROVIDER RENEWAL**
  - 3.1 The local EMS Agency shall renew CE provider approval if they meet the requirements contained in the state guidelines and this policy.
  - 3.2 It is the responsibility of the CE provider to submit an application for renewal at least sixty (60) calendar days before the expiration date in order to maintain continuous approval.
4. **APPLICATION**
  - 4.1 The applicant shall submit an application packet and any required fees to the local EMS Agency at least sixty (60) calendar days prior to the date of the first activity.
  - 4.2 The application packet shall contain the following:
    - > Application form
    - > Resumes of CE Program Director and Clinical Director demonstrating that individual's experience and qualifications in prehospital care/education.

- > Samples of course objectives, a class outline, and a post exam
- > A sample course completion certificate

5. CE PROVIDER REQUIREMENTS

Approved CE providers shall ensure that:

- 5.1 The content of all CE is relevant, enhances the practice of prehospital emergency medical care, and is related to the knowledge base or technical skills required for the practice of emergency medical care.
- 5.2 Records are maintained for four years and shall contain the following:
  - > complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance;
  - > record of time, place, date each course is given and the number and type of hours granted;
  - > a curriculum vitae or resume for each instructor;
  - > a roster signed by course participants to include name and certification/license number of prehospital care personnel taking any approved course and a record of any certificates issued.
- 5.3 The local EMS Agency is notified within thirty (30) calendar days of any change in name, address, phone number, program director or clinical director.
- 5.4 All records are available to the approving agency upon request, A CE provider is subject to scheduled site visits by the local EMS Agency.
- 5.5 Individual classes/courses are open for scheduled or unscheduled visits by the local EMS Agency.
- 5.6 Copies of all advertisements disseminated by CE providers publicizing CE shall be sent to the local EMS Agency prior to the beginning of the course/class.

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APPROVAL



Bruce E. Haynes, M.D.  
EMS Medical Director

**APPLICATION  
IMPERIAL COUNTY  
AUTHORIZATION AS APPROVED PROVIDER  
OF  
PREHOSPITAL CONTINUING EDUCATION (CE)**

(Please print or type)

1. CE PROVIDER NAME: \_\_\_\_\_

2. PHONE #: \_\_\_\_\_

3. FAX #: \_\_\_\_\_

4. PROVIDER HEADQUARTERS: \_\_\_\_\_

(number & street, city, state, zip)

5. PROVIDER MAILING ADDRESS: \_\_\_\_\_

(if different from above)

6. CONTINUING EDUCATION PROGRAM DIRECTOR: \_\_\_\_\_

7. CONTINUING EDUCATION CLINICAL DIRECTOR: \_\_\_\_\_

8. PROVIDER IS A/AN: (check one)

Local EMS Agency

University/College

Base Hospital

Other School

Other Hospital

Other Government Agency

Service Provider

Individual

EMT-P Training Program

Other CE Provider

9. ATTACH:

a. Resumes of CE Program Director and Clinical Director, demonstrating that individual's experience and qualifications in prehospital care/education (see guidelines).

b. Application fee or proof of payment - \$ \_\_\_\_\_.

I certify that I have read and understand the "California Prehospital Continuing Education Guidelines" and the Imperial County EMS Agency Policy governing Continuing Education, and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit and review provisions described. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.

Date: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE - CE Program Director

(Local EMS Agency Use)

Application Rec'd Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Approval Date: \_\_\_\_\_

Renewal Date: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Fee Paid Date: \_\_\_\_\_

CE Level: BLS ALS Both      Comments: \_\_\_\_\_

**IMPERIAL COUNTY PUBLIC HEALTH DEPARTMENT  
EMERGENCY MEDICAL SERVICES AGENCY**

935 Broadway, El Centro, CA 92243

(760) 482-4468

Fax (760) 482-4519

E-mail: [johnpritting@imperialcounty.net](mailto:johnpritting@imperialcounty.net)

*Bruce Haynes, M.D.  
EMS Medical Director*

*John W. Pritting, M.B.A.  
EMS Manager*

**EMS CONTINUING EDUCATION**

**PROVIDER AGREEMENT**

An approved CE Provider in Imperial County shall:

1. Ensure that the content of all CE is relevant, enhances the practice of prehospital emergency medical care, and is related to the knowledge base or technical skills required for the practice of emergency medical care.
2. Maintain CE records for four (4) years to include:
  - Complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance;
  - Record of time, place, date each course is given and the number and type of hours granted;
  - A curriculum vitae or resume for each instructor;
  - A roster signed by course participants to include name and certification/license number of prehospital care personnel taking any approved course and a record of any certificates issued.
3. Notify the Local EMS Agency within thirty (30) calendar days of any change in name, address, phone number, program director or clinical director.
4. Ensure that all records are available to the approving agency upon request. A CE Provider is subject to scheduled site visits by the Local EMS Agency.
5. Notify the Local EMS Agency in advance of all CE classes to allow for scheduled or unscheduled visits by the EMS Agency Coordinator/representative.

6. Ensure that copies of all advertisements disseminated by the CE Provider publicizing CE shall be sent to the Local EMS Agency prior to the beginning of the class.
7. Participate in the approved EMS System-wide Continuous Quality Improvement program.

I certify that I have read and understand the "California Prehospital Continuing Education Guidelines" and the Imperial County EMS Policy governing CE, and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audits and review provisions described. I understand that failure to comply with these provisions will result in termination of this agreement and my/this agency's CE Provider status.

**CE PROVIDER:**

\_\_\_\_\_  
Signature – CE Program Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency

**APPROVING AUTHORITY:**

\_\_\_\_\_  
Signature – EMS Medical Director

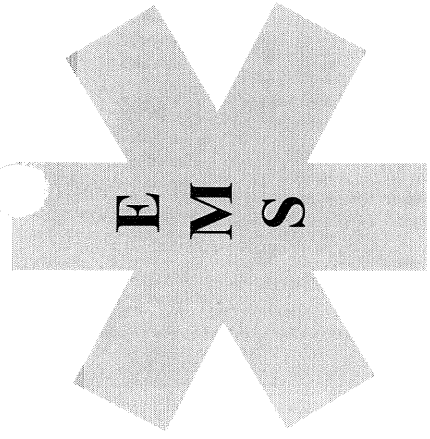
\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – EMS Manager





*Imperial County Public Health Department  
Emergency Medical Services Agency  
935 Broadway  
El Centro, CA 92243  
(760) 482-4468*



**EMERGENCY MEDICAL SERVICES  
CONTINUING EDUCATION**

This is to certify that

«Title»

«Name»

«Certification/License Number»

has successfully completed a course of instruction in

«Class»

Date: \_\_\_\_\_ Course Director: \_\_\_\_\_

This course has been approved for \_\_\_\_\_ hours of Continuing Education  
By California EMT-P CE Provider #13-\_\_\_\_\_  
This document must be retained for a period of four (4) years.

**GUIDELINES FOR PREHOSPITAL CONTINUING EDUCATION  
EMSA #127**

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**PREHOSPITAL CONTINUING EDUCATION GUIDELINES**

**I. INTRODUCTION**

These guidelines have been prepared with the following concepts in mind:

- Prehospital personnel are professionals and, as such, take the responsibility for ensuring that their continuing education requirements are met, in accordance with their individual needs.
- Continuing education is a means by which prehospital personnel may achieve excellence in their profession.
- Continuing education focuses on the ongoing performance of prehospital personnel and their interaction with other team members, rather than on basic education.
- Continuing education providers must have appropriate training, credentials and experience in educational principles in order to ensure that the courses given adequately address the educational needs of the prehospital personnel.
- EMT-Is, EMT-IIs and EMT-Ps should have similar structures for continuing education approval.

**A. Purposes and Goals of Continuing Education Guidelines**

- The purposes of these guidelines, established by the California EMS Authority in consultation with the Continuing Education (CE) Task Force, are to:
  - provide direction to local EMS agencies in approving CE providers;
  - define the roles and responsibilities of CE providers; and
  - provide information for prehospital personnel (EMT-I, EMT-II and EMT-P).
- The goal of these guidelines is to specify those requirements which will promote uniformity throughout California in the provision and acceptance of CE statewide for prehospital personnel. These guidelines have been structured to follow the same order as the above outlined purposes. In addition, this document contains seven (7) Appendices. Care was given in the design to allow reproduction of each appendix as needed for any of the intended users.
- These guidelines will be a dynamic document and will be modified as we gain more experience in providing continuing education.

## **B. Statutory and Regulatory Authority**

These continuing education guidelines are issued pursuant to Sections 1797.170, 1797.171, 1797.172, 1797.174, and 1797.175, Health and Safety Code and Sections 100080, 100124, 100165, 100165.1, 100165.2 and 100165.3, Title 22 of the California Code of Regulations. These sections authorize the EMS Authority to establish and specify the training standards for all prehospital personnel, including standards for continuing education.

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## **II. CONTINUING EDUCATION APPROVING AGENCY RESPONSIBILITIES**

The approving agencies are designated local EMS agencies and the EMS Authority. These agencies have the primary responsibility for approving and monitoring the performance of CE providers to ensure compliance with these guidelines and established local policies.

Approving agencies shall approve CE providers pursuant to state regulations, these guidelines and established local policies. The approval process shall be implemented by the approving agency through policies, and fees may be charged to cover the cost of approving and monitoring the CE programs. Compliance with these guidelines will eliminate duplication of approval of CE providers and CE courses between jurisdictional boundaries.

### **A. CE Provider Approval Process**

#### 1. General

- The designated local EMS agency shall be the approving agency for CE providers whose headquarters are located in its county or region.
- If the CE provider relocates its headquarters to another jurisdiction, the local EMS agency of that county shall assume jurisdictional authority and may require the CE provider to reapply for CE provider status.
- The California EMS Authority shall be the approving agency for CE providers whose headquarters are out of state and for statewide public safety agencies.

#### 2. CE Provider Application Process

Interested organizations or individuals shall submit an application to the approving agency. It is recommended that the application contain information as specified in the sample application contained in Appendix D. See also Section III (B) on page 6.

- The approving agency shall notify the applicant within fourteen (14) days that the application was received.
- The approving agency shall notify the applicant in writing within sixty (60) calendar days from the receipt of a complete application of its decision to approve or disapprove.

- The application shall be considered for approval if it is complete and all requirements are met as specified in Section III of these guidelines.
- Failure to submit missing information within thirty (30) calendar days of request will require the applicant to reapply for CE provider status.
- The approving agency may deny an application for cause as specified in subsection B of this section.
- The approving agency must issue a "CE provider number" to approved applicants in accordance with state regulations and these guidelines (see Appendix B).
- Program approval shall be issued for no more than four (4) years. The expiration date shall be no more than four years from the last day of the month in which the application is approved.

#### **B. Disapproval/Revocation/Probation of CE Provider Status**

1. The approving agency may, for cause, disapprove an application for approval of CE provider, revoke CE provider approval or place the CE provider on probation.
2. Causes for these actions include, but are not limited to the following:
  - Violating or attempting to violate any of the provisions of Sections 100080, 100124, 100165, 100165.1, 100165.2 and 100165.3, Title 22 of the California Code of Regulations, the guidelines, or established local policies.
  - Failure to correct identified deficiencies within a reasonable length of time after receiving written warning notices specifying the deficiencies from the approving agency.
  - Any material misrepresentation of fact by a CE provider or applicant in any information required.
3. The approving agency may take such action(s) as it deems appropriate after giving written notice and specifying the reason(s) for disapproval, revocation or probation.
4. If an application for CE provider status is disapproved or CE provider status is revoked, the applicant/CE provider should make good faith efforts to correct identified deficiencies. The approving agency should also make a good faith effort to assist the applicant/CE provider in those efforts.
5. If CE provider status is disapproved or revoked, approval for CE credit will be withdrawn for all CE programs scheduled after the date of action.
6. If a CE provider is placed on probation, the terms of probation, including approval of an appropriate corrective action plan, shall be determined by the approving agency. This corrective action plan may include submission of all course documentation to the approving agency no later than thirty (30) calendar days prior to each course being offered during the probationary period. In these cases, written notification of course approval shall be sent to the CE provider within ten (10) calendar days of the receipt of the request.
7. Renewal during probation is contingent upon successful implementation of the approved corrective action plan.

#### **C. Dissemination & Notification of CE Provider Information**

1. The approving agency is responsible for disseminating the requirements for CE approval to prospective CE providers, currently approved CE providers and prehospital personnel through various methods (e.g., local policies, newsletters, provider liaisons, etc).
2. The approving agency shall notify the EMS Authority of each CE provider approved, disapproved or revoked within its jurisdiction within thirty (30) calendar days of action. Required information shall be established by the EMS Authority (see Appendix E).

The EMS Authority shall maintain a list of all approved, disapproved or revoked CE providers. This information shall be made available to local EMS agencies on a quarterly basis.

#### **D. CE Provider Renewal**

An approving agency shall renew CE provider approval if they meet the requirements contained in these guidelines and in established local policies.

Return to the [Table of Contents](#)

### **III. CONTINUING EDUCATION PROVIDER REQUIREMENTS AND RESPONSIBILITIES**

In order to be approved as a CE provider, the following requirements and responsibilities shall be satisfied.

#### **A. General**

Any individual or organization, public or private, interested in providing approved continuing education for prehospital providers shall apply to the approving agency with jurisdictional authority for CE provider approval.

#### **B. Application**

1. The applicant shall submit an application packet and any required fees to the approving agency at least sixty (60) calendar days prior to the date of the first activity. See Appendix D for application information requirements.

2. The application shall contain, at a minimum, the following:

provider name and headquarters address;

the name(s) and qualifications of the program director and clinical director; and

a signed statement verifying adherence to state and local EMS CE guidelines.

3. Provider approval is non-transferable.

#### **C. CE Provider Renewal**

1. It is the responsibility of the CE provider to submit an application for renewal at least sixty (60) calendar days before the expiration date in order to maintain continuous approval.

2. All CE provider requirements must be met and maintained for renewal.

#### **D. CE Provider Requirements**

Approved CE providers shall ensure that:

1. The content of all CE is relevant, enhances the practice of prehospital emergency medical care, and is related to the knowledge base or technical skills required for the practice of emergency medical care.

2. Records are maintained for four years and shall contain the following:

- complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance, if appropriate;
- record of time, place, date each course is given and the number and type of hours granted;
- a curriculum vitae or resume for each instructor;
- a roster signed by course participants to include name and certification/license number of prehospital care personnel taking any approved course and a record of any certificates issued.

3. The approving agency is notified within thirty (30) calendar days of any change in name, address, telephone number, program director or clinical director.

4. All records are available to the approving agency upon request. A CE provider is subject to scheduled site visits by the approving agency.

5. Individual classes/courses are open for scheduled or unscheduled visits by the approving agency and/or the local EMS agency in whose jurisdiction the course is given.

#### **E. Training Program Staff Requirements**

Each CE provider shall provide for the functions of administrative direction, medical quality coordination and actual program instruction through the designation of a program director, a clinical director and instructors. Nothing in this section precludes the same individual from being responsible for more than one of the functions.

#### 1. Program Director:

- Each CE provider shall have an approved program director who is qualified by education and experience in methods, materials and evaluation of instruction. Program director qualifications shall be documented by one of the following:
- California State Fire Marshal (CSFM) "Fire Instructor 1A and 1B" or the National Fire Academy (NFA) "Fire Service Instructional Methodology" course or equivalent; or
- University of California (UC)/California State University (CSU) sixty (60) hours in "Techniques of Teaching" courses or four (4) semester units of upper division credit in educational materials, methods and curriculum development or equivalent.
- Individuals with experience may be provisionally approved for up to two years by the approving agency pending completion of the specified requirements. Individuals with experience in areas where training resources are limited and who do not meet the above Program Director requirements may be approved upon review of experience and demonstration of capabilities.

#### Duties of the Program Director

- The duties of the program director shall include, but not be limited to:
  - administering the CE program and ensuring adherence to state regulations, these guidelines and established local policies;
  - approving course content including instructional objectives (Appendix A), and assigning course hours and category of any CE program which they sponsor;
  - approving all methods of evaluation;
  - coordinating all clinical and field activities approved for CE credit;
  - approving the instructor(s); and
  - signing all course completion records and maintaining those records in a manner consistent with these guidelines. The responsibility for signing course completion records may be delegated to the course instructor.
- #### 2. Clinical Director:
- Each CE provider shall have an approved clinical director who is currently licensed or certified in good standing as a physician, registered nurse, physician assistant, or EMT-P.
  - The clinical director shall have two years of academic, administrative or clinical experience in emergency medicine or prehospital care within the last five (5) years.

#### Duties of the Clinical Director

- The duties of the clinical director shall include, but not be limited to monitoring all clinical and field activities approved for CE credit, approving the instructor(s), monitoring the overall quality of the prehospital content of the program.

#### 3. Instructor:

- Each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, and shall be currently licensed or certified in their area of expertise, if appropriate; 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 or activity.

#### **F. Continuing Education Hours (CEH)**

The CE provider will identify hours of approved continuing education on the following basis:

1. One continuing education hour (CEH) is awarded for every fifty (50) minutes of approved content.
2. Courses or activities less than one (1) CEH in duration will not be approved.
3. For courses greater than one (1) CEH, credit may be granted in no less than half hour increments.
4. Each hour of structured clinical experience shall be accepted as one (1) CEH.
5. One academic quarter unit shall equal ten (10) CEHs.
6. One academic semester unit shall equal fifteen (15) CEHs.

#### **G. Record Keeping**

Each CE provider shall maintain for four (4) years:

1. Records on each course including, but not limited to, course title, course objectives, course outlines, qualification of instructors, dates of instruction, location, participant sign-in rosters, sample course tests, or other methods of evaluation, and records of course completions issued.
2. Summaries of test results, course evaluations, or other methods of evaluation. The type of evaluation used may vary according to the instructor, content or program, number of participants and method of presentation.

#### **H. Certificates and Documents as Proof of Completion**

1. Providers shall issue to the participant a tamper resistant document or certificate of proof of successful completion of a course within ten (10) calendar days.
2. The certificate or documentation of successful completion must contain the following information:
  - Name of participant and certification/license number.
  - Course title.
  - CE provider name and address.
  - Date(s) of course.
  - Signature of program director or course instructor.

In addition, for EMT-P participants, the following statements, MUST be printed on the certificate of completion with the appropriate information filled in:

- "This course has been approved for (number) Hours of Category (I or II) EMT-P Continuing Education by California EMT-P CE Provider "
- "This documentation must be retained for a period of four (4) years"
- "California CE Provider # \_\_\_\_\_ - \_\_\_\_\_"

## **I. Advertisement**

Information disseminated by CE providers publicizing CE must include at a minimum the following:

1. provider's policy on refunds in cases of nonattendance by the registrant or cancellation by provider, if applicable;
2. a clear, concise description of the course content, objectives and the intended target audience (e.g. ALS/LALS/BLS or all);
3. provider name, as officially on file with the approving agency; and
4. specification of the number of CE hours to be granted.

Copies of all advertisements disseminated to the public shall be sent to the approving agency and the local EMS agency in whose jurisdiction the course is presented prior to the beginning of the course/class. In addition to the above, if course is to be provided to EMT-Ps, the following statement shall be printed: "This course has been approved for \_\_\_\_\_ hours of Category I or II continuing education by Prehospital CE provider # \_\_\_\_-\_\_\_\_".

## **J. Co-sponsoring a course**

When two or more CE providers co-sponsor a course, only one approved provider number will be used for that course, and that CE provider assumes the responsibility for all applicable provisions.

## **K. Sponsorship of One Time Activity/Course**

An approved CE provider may sponsor an organization or individual 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.

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## **APPENDIX A**

### **INSTRUCTIONAL OBJECTIVES**

Instructional objectives are the basis for determining the content of a program. Instructional objectives are the expectations of the instructor for program participants and measure their behavioral changes. Instructor goals are not instructional objectives. Instructional objectives enable the instructor and participant to attain program goals.

Instructional objectives have three components:

- performance
- condition
- criterion

Performance refers to what the participant is expected to do. Condition refers to what requirements must be present to meet the objective. Criterion refers to what standard is used to measure the achievement of the objective. Two examples of complete instructional objectives are:

- At the conclusion of this session, the participant will be able to identify correct hand placement for adult CPR (performance) on a manikin (condition) according to the standards of the American Heart Association (criterion).
- Upon completion of this unit of instruction, the participant will identify three essential components of CPR (performance) in writing (condition) with 100% accuracy (criterion).

Further information on instructional objectives may be found in *Preparing Instructional Objectives* by Robert F. Mager (Lake Publishers, Belmont, CA).

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## APPENDIX C

### CATEGORIZATION OF PREHOSPITAL CONTINUING EDUCATION

Purpose:

- Prehospital continuing education must be relevant to and enhance the practice of prehospital emergency medical care. The goal of prehospital CE should be to renew, enhance and enrich the practice of prehospital care by field personnel, to maintain knowledge and skills and to provide exposure to new or advanced material.
- When granting CE credit the guiding rules should be that CE credit is given to courses or classes that are directly or indirectly related to patient care and are structured, with learning objectives and an evaluation component. If a proposed activity meets these two objectives, then it qualifies for CE credit.

Application to EMT-IIs and EMT-IIIs:

EMT-I CE is currently not categorized; however, CE for EMT-IIs is generally equivalent to Category I-type training. The EMT-I regulations require twenty four (24) hours of classroom and lab instruction (not including testing) in BLS knowledge and skills for recertification. EMT-II CE is also not categorized; however, field care audit requirements are generally equivalent to Category II-type training. The periodic training and structured clinical experience for EMT-IIIs are generally equivalent to Category I type training.

Application to EMT-PIs:

EMT-P CE is classified as Category I (Didactic Education) and Category II (Field Care Audit). These CE categories are further defined as follows.

**1. CATEGORY I - Didactic** - Didactic education should be planned and presented with specific instructional objectives which address ALS and/or BLS skills or knowledge relating to direct/indirect patient care by prehospital personnel. This category may include classroom presentation, seminar or workshop experience, structured clinical experience, home study courses or video presentation.

#### 1.1 Acceptable topics and examples:

- Courses in physical, social or behavioral sciences (e.g., anatomy, pathophysiology, sociology, psychology).
- Knowledge relating to direct prehospital patient care, including medical treatment and/or management of specific patients (e.g., burn care, assessment, ACLS, BTLIS, orientation programs with patient care contact).
- Structured clinical experience to review or expand the clinical expertise of the individual. All clinical time must have specific goals and account for downtime (e.g., assessment skills, clinical rounds) and shall be allowed for a maximum of eight (8) hours in a certification cycle.
- Knowledge applied to indirect patient care or medical operations (e.g., quality improvement, cultural diversity, grief support, CISD, medical management of hazardous materials, emergency vehicle operations, dispatch, rescue techniques).
- Advanced topics in subject matter outside the scope of practice of prehospital personnel but directly relevant to prehospital care (e.g., surgical airway procedures).
- Media based and/or serial productions (e.g., films, video "magazines", audiotape programs, magazine article offered for CE credit, home study, computer simulations or interactive computer modules). Media based courses must be individually approved and must stand alone as a coherent and complete CE program, which includes objectives, written evaluation tool and verification of participation.

#### 1.2 Courses which are not acceptable as prehospital didactic education:

- Courses that focus upon self-improvement (e.g., personal growth, changes in attitude, self-therapy, self-awareness, weight loss, yoga)
- Economics courses for financial gain
- Parenting, Lamaze or other courses designed for the lay public
- Liberal arts courses (e.g., music, art, philosophy)
- Workplace orientation (e.g., specific employer orientation)
- Writing a journal article or conducting emergency medical services research
- Fire science courses
- Precepting students

**2. CATEGORY II Field Care Audit (FCA)** - FCA is an organized review of field care using actual recorded or written patient care records. FCA should focus primarily on treatment, interventions and local policies. Didactic material may be presented as part of a FCA if the discussion is related to the cases being reviewed and is limited to fifty percent of the content.

This category may include:

- Structured classroom setting to review actual recorded tapes or patient care records (PCRs). Cases chosen for review should be selected for their educational value. In addition, anonymity for the patient and for the prehospital personnel should be established, when possible. If this is not possible, advance notice to the prehospital personnel involved should be given. Goals and objectives should be prepared for each FCA.
- Participation by an individual in a structured audit that utilizes tapes or PCRs. Credit is given hour for hour during the review period and must include an evaluation component.
- Peer review or committees formed to review prehospital patient care that are structured and that meet these guidelines (e.g., objectives, evaluation component).

Limitations

- An individual may receive credit for taking the same CE course no more than two times during the same certification cycle.
- A maximum number of eight (8) hours shall be credited for course instruction.

Reciprocity:

- Continuing Education Coordinating Board for Emergency Medical Services (CECSBEAMS) approved courses will be accepted for Category I CE credit.
-

- I. Authority: California State Board of Pharmacy Business and Professions Code, Section 4019,4021, CCR Title 22, Division 5, Chapter 5, Section 70001, and D.E.A. 21 Code of Federal Regulations 1301.28.
- II. Purpose: To define a procedure to ensure accountability for all controlled and uncontrolled drugs issued to ALS/LALS providers.
- III. Policy:

A. Uncontrolled Drugs

1. All ALS/LALS providers must have a policy in place that designates:
  - a. Procedures for ordering and storing medications to protect from temperature extremes and prevent adulteration.
  - b. Procedures for completing a monthly inventory, which includes checking:
    - Inventory quantities
    - Medications stored in original packaging.
    - Expiration dates.
  - c. Procedures for issuing medications.
  - d. Procedures for handling discrepancies in drug inventory to include reporting and recording discrepancies.
  - e. Procedures for exchanging/returning expired/recalled/broken medications.

B. Controlled Drugs

(Definition -pharmaceutical drugs categorized as Category II, III or IV to include morphine sulfate and midazolam)

1. Initial Stocking of Units
  - a. Controlled drugs will be issued by the Base Hospital Pharmacy to ALS/LALS Units in accordance with DEA regulations.

- b. All controlled drugs must be kept under double lock and key system.
    - c. It is recommended that all controlled substances be issued in tamper evident containers.
  2. Resupplying of Controlled Drugs to Units
    - a. When a controlled drug is used in the field, resupply shall be provided on a one-to-one basis by the Pharmacist (or designee) at the receiving hospital.
      - ALS/LALS personnel must waste unused drugs in the presence of the Emergency Department Registered Nurse at the receiving hospital. The hospital controlled drug record must include the amount of drug wasted and the signatures of both the RN and the ALS/LALS personnel.
      - A new morphine Tubex should be issued in a tamper evident container to the ALS/LALS personnel.
    - b. Drugs that have passed the expiration date or incurred breakage must be replaced by the Pharmacist (or designee) at the Base Hospital. The broken or out-dated drug must be presented to receive a replacement.
    - c. Only a currently licensed EMT -II, Paramedic, Registered Nurse or Physician shall sign for replacement drugs.
  3. Controlled Drug Recordkeeping by ALS/LALS personnel:
    - a. Each ALS/LALS Unit shall maintain a standardized written record of controlled drug inventory. These records shall be maintained by the agency for a period of seven (7) years in compliance with the State Board of Pharmacy.

- b. Drugs shall be inventoried by the on-coming and off-going ALS/LALS personnel at each shift change, and documentation shall include the signatures of the person(s) performing the inventory and noted on the controlled drug inventory.
    - c. Any discrepancy between the written ALS/LALS Unit controlled drug inventory and the actual count of on-board drugs shall be noted on the controlled drug inventory sheet and shall be signed by the ALS/LALS personnel who noted the discrepancy. A written report of the discrepancy must be submitted to the Base Hospital Pharmacist and the EMS Agency Medical Director within 24 hours.
  4. Controlled Drug Inspection/Audit of ALS/LALS Units:
    - a. Periodic, announced or unannounced inspections or audits of controlled drugs and/or controlled drug inventory records may be conducted by the Base Hospital Pharmacist (or designee) or the EMS Agency Medical Director (or designee) at any time to document and ensure compliance with this policy.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

1. Prior to Base Hospital contact:

ALS/LALS personnel may institute specified procedures and administer medications before attempting voice contact with a physician or Mobile Intensive Care Nurse. Those procedures and medications are indicated in the Treatment Protocols by the notation **SO** (Standing Orders).

Those procedures and medications that require Base Hospital contact prior to being performed are represented by the abbreviation **BH** (Base Hospital contact). Those procedures and medications that require Base Hospital Physician approval prior to being performed are represented by the abbreviation **BHP** (Base Hospital Physician).

2. ALS/LALS personnel will contact the Base Hospital:

- For any patient who would benefit from consultation with the Base Hospital regarding general assessment and/or patient management.
- At any point in a policy or patient care protocol where Base Hospital contact is required for medication, treatment or procedure.
- For any patient who refuses medical treatment or transportation and does not meet the criteria for refusal in accordance with Policy #1500.
- For any patient who is attended by a physician at the scene and that physician wishes to recommend treatment or assume responsibility for the patient's care.
- The time of Base Hospital contact and the name of the MICN or physician contacted must be documented on the Patient Care Report Form. ALS/LALS personnel may receive medical direction only from the Imperial County authorized Base Hospital.

3. Disrupted communications:

- In situations where required Base Hospital contact cannot be established, maintained, or an MICN / Base Hospital Physician is unavailable, and in the

of ALS/LALS personnel, the patient's condition warrants ALS medical intervention, ALS/LALS personnel may institute the emergency treatment as specified in the appropriate ALS protocol. ALS/LALS personnel should include documentation of disrupted communications on the Patient Care Report Form.

- ALS/LALS personnel will notify the Base Hospital as soon as they reach a Receiving Hospital or upon returning to quarters. The Communication Failure Report Form (see attached) must be completed including all communication attempts, the nature of the disruption, and any pertinent facts. The Report Form must be submitted along with a copy of the PCR to the Base Hospital within 24 hours of the occurrence.

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**APPROVAL**



Bruce E. Haynes, M.D.

EMS Medical Director

IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES AGENCY

COMMUNICATION FAILURE REPORT FORM

This form is to be completed whenever a patient's condition warrants ALS/LALS medical intervention and Base Hospital radio/telephone contact cannot be established, maintained, or when the Base Hospital MICN or Physician is not available. Attach form to PCR and submit to Base Hospital Coordinator for review.

Report initiated by: \_\_\_\_\_ Title: \_\_\_\_\_

Date of incident: \_\_\_\_\_ Agency & Unit #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Receiving Hospital: \_\_\_\_\_

List attempts made to establish communications and explain problems encountered:

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(Attach additional sheets as needed)

If Base contact was made and no MICN/Physician available, explain why (example: no MICN on duty, physician unable to leave patient, etc.):

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Incident Summary (include patient's condition and treatment given under communication failure protocol):

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(Attach additional sheets as needed)

Reporting Party: \_\_\_\_\_ Date: \_\_\_\_\_

Signature

IMPERIAL COUNTY  
EMERGENCY MEDICAL SERVICES AGENCY

COMMUNICATION FAILURE INVESTIGATION FORM

Base Hospital Coordinator: \_\_\_\_\_ B.H. Run # \_\_\_\_\_

Prehospital Personnel Involved: \_\_\_\_\_ Title/Cert #: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROBABLE CAUSE OF COMMUNICATION FAILURE

- |   |   |
|---|---|
| <input type="checkbox"/> Equipment Failure            | <input type="checkbox"/> Poor reception |
| <input type="checkbox"/> MICN/Physician not available | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Unknown                      |   |

Explanation: \_\_\_\_\_

\_\_\_\_\_  
(use additional sheets as needed)

Were Communication Failure protocols followed? \_\_\_\_\_

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

Was the field treatment appropriate for the patient condition? \_\_\_\_\_

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

Problems identified: \_\_\_\_\_

Actions taken: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SUBJECT: ALS/LALS UNIT INVENTORY**

**POLICY # 4110**

**I. Purpose:** Identify a minimum standardized inventory on all ALS/LALS Units.

**II. Policy:** In addition to the essential equipment and supplies required by California Code of Regulations, Title 13, Section 1103.2, ALS and LALS Units shall carry the following minimum inventory in accordance with their scope of practice:

**INVENTORY (ADULT)**

**MINIMUM**

**A. Airway Adjuncts:**

* Bag-valve-mask device with reservoir	1 each
* Endotracheal Tubes: Sizes: 6.5,7,7.5,8,8.5,9	1 each
Combitube (Kit): regular and small adult	1 each
Esophageal detector device (Toomey syringe or self-inflating bulb)	1 each
Laryngoscope - handle	2 each
Laryngoscope - Blade: curved and straight sizes 3-4	1 each
* Magill Forceps	1 each
Nasal Airways, assorted sizes	1 package
* Oxygen Powered Nebulizer	1 each
* Oxygen Cannula (except for pediatric sizes)	2 each
* Positive Pressure Breathing Valve (Mask must be latex-safe)	1 each
* Stylet	1 each
* Suction Catheters (12,14,18 Fr.)	1 each
Suction Catheters, Tonsil Tip (Yankauer)	3 each

**B. Vascular Access/Monitoring Equipment**

* Armboard: Long	2 each
* Armboard: Short	2 each
Blood Glucose Monitoring Device	1 each
* Blood Pressure Cuff	1 each
* IV Administration Sets: Macro drip	6 each
Micro drip	3 each
* IV Tourniquets	4 each
* Safe Needle Devices:	
IV Scalp Veins (Gauges - 19,21,23)	2 each
IV Cannula (Gauges - 14,16,18,20)	4 each
IM - 21 Gauge X 1"	4 each
SC - 25 Gauge X 3/8"	4 each
* Saline Lock	4 each
* Syringes: 1 mL, 3 mL, 5 mL, 10 mL, 20 mL	2 each
* Stethoscope	1 each

**C. ECG Monitoring**

* Conductive Gel/Defibrillator pads	1 tube/2 pkgs
Defibrillator/Scope Combination	1 each
* Electrodes	1 box
Electrode Wires	2 sets

**INVENTORY (ADULT)**

**MINIMUM**

D. Splinting Devices:

- \* Extrication Collars, Rigid, Adult sizes (small, medium, large) 2 each
- \* Traction Splint 1 each

E. Packs

- Drug Box 1 each
- Trauma Box/Pack 1 each

F. Other Equipment

- \* Cold Packs 2 each
- \* Hot Packs (temperature limit of 110 degrees) 2 each
- \* Personal Protective Equipment (refer to Policy #4250) 2 sets
- Restraints, soft or leather 1 set
- Water Soluble Lubricant 1 each

G. Communication Items

- EMS Radios - both mobile and portable (800 MHz) 1 each
- (Cell phone may be substituted for UHF radios) 1 each

H. Replaceable Medications:

- Albuterol 2.5 mg/3 mL 4 vials
- Activated Charcoal, 50 gm 1 each
- Aspirin, chewable, 80 mg 8 units
- Atropine Sulfate, 0.5 mg/5 mL 6 each
- Atropine Sulfate, multidose 0.4 mg/mL 1 each
- Calcium Chloride, 1 gm/10 mL 1 each
- Dextrose, 50%, 25 gm/50 mL (for pediatrics: 25%, 12.5 gm/50 mL) 2 each
- Dopamine HCL, 400 mg 1 each
- Diphenhydramine HCL, 50 mg/2 mL 2 each
- Epinephrine, 1:1,000 (multidose vial) 1 each
- Epinephrine, 1:1,000 (1 mg/mL) 4 each
- Epinephrine, 1:10,000 (1 mg/10 mL) 6 each
- Glucagon, 1 mL (1 unit) 1 each
- Glucose paste 1 tube
- Lidocaine HCL, 100 mg/5 mL (2%) 6 each
- Midazolam, 1 mg/mL 10 mg
- Morphine Sulfate, 10 mg/1 mL 2 each
- Naloxone, 2 mg/mL 6 each
- Nitroglycerin, 0.4 mg (tablets or spray) 1 bottle
- Verapamil HCL, 5 mg/2 mL 2 each

**INVENTORY (ADULT)**

**MINIMUM**

\* IV Solutions

Normal Saline, 250 mL bag

4 each

Normal Saline, 1000 mL bag

6 each

I. Optional Items

12-Lead ECG Monitor

End tidal CO2 detector

Oxygen saturation monitoring device

ECG Monitor with External Pacing Capability

Pacing Wires

\* Electrode Pads

**INVENTORY (PEDIATRICS)**

**MINIMUM**

1. AIRWAY

\* Bag-valve-mask device with reservoir (250 mL, 500 mL, 1000 mL)

1 each

\* and the following interchangeable masks: premature size

1 each

neonate size

1 each

child size

1 each

Laryngoscope - Blades curved and straight sizes 0, 1, 2

1 each

Magill Forcep - small

1 each

Oral Airways 0-5

1 each

Oxygen Mask (non-rebreather), pediatric

2 each

\* Suction Catheters (5, 6, 8, 10 Fr)

1 each

2. BIRTH

\* Bulb Syringe

1 each

Blanket for Newborn (OB kit)

1 each

Sterile Scissors (or scalpel from OB kit)

1 each

Umbilical Clamps/Ties/Tape (OB kit)

1 each

3. IMMOBILIZATION

\* Extrication Collars, Rigid, Child (small, medium, large)

2 each

\* Traction Splint - Pediatric

1 each

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**INVENTORY (PEDIATRICS)**

**MINIMUM**

**4. VASCULAR ACCESS/MONITORING DEVICES**

Defibrillator Paddles	1 pair
* IV Cannula (22, 24 Gauge)	4 each
* IV Scalp Vein (25 Gauge)	2 each
* Blood Pressure Cuff (infant and child size)	1 each
Centimeter Tape Measure	1 each
Pediatric Drug Guide (laminated)	1 each
Volutrol	1 each

**\* Latex Sensitivity**

Prehospital provider agencies shall attempt, when possible, to use patient equipment that minimizes exposure to latex containing products. All items denoted by an asterisk (\*) are essential equipment that must be available for use with patients identified as latex-sensitive. Barrier protection is acceptable.

Prehospital staff should minimize their own exposure to latex products at all times.

Staff shall be knowledgeable in procedures to use latex-containing products in a latex-safe manner.

Such methods include:

1. Barrier protection measures (example - for stethoscope). If barrier protection is used, materials should be easily available to implement the barrier;
2. Procedures to remove or cover latex-containing parts (such as caps on multi-dose medication vials).

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**APPROVED:**



Bruce Haynes, M.D.  
EMS Medical Director

1. The Receiving Hospital will be notified of patient's enroute to its facility by the following procedure:
    - 1.1 When communication has been established with the Base Hospital by mobile unit the MICN or BHP shall notify the Receiving Hospital emergency room physician or nurse on duty with the following information: a patient profile, prehospital medical care rendered, patient's response to treatment, and ETA at the Receiving Hospital. This notification shall be documented on the Base Hospital patient report form.
    - 1.2 When communication has NOT been established with the Base Hospital either because of disrupted communication (see Policy #1300) or because BH contact, is not required (i.e. patients not requiring ALS intervention or patients treated with ALS standing orders and no further orders requiring BH contact needed), mobile units will contact receiving hospital directly.
  2. Receiving Hospital staff (other than Base Hospitals) shall not give treatment orders to prehospital ALS/LALS/BLS providers. Pre hospital care providers shall not accept any treatment orders from a receiving hospital not designated as a Base Hospital. However, receiving hospital may request mobile unit contact BH for consideration of ALS intervention.
  3. Base Hospital contact may be made for any patient who, in the opinion of the prehospital care provider, would benefit from a consultation with the Base Hospital regarding general assessment and/or patient management.
- 

**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

The decision to permit any patient to refuse emergency medical treatment and/or transportation rests with the Base Hospital physician on duty. When a patient refuses emergency medical evaluation, treatment, or transportation:

- A. The patient refusing medical care must be:
1. Competent – means the patient has the capacity to understand the circumstances surrounding his/her illness or impairment, and the risks associated with refusing treatment or transport. The patient's judgment is not significantly impaired by illness, injury or drugs/alcohol intoxication.
  2. Able to make his/her own medical decisions to include being:
    - a. At least 18 years of age or older
    - b. A minor (under age 18) that is lawfully married, divorced, or had an annulment
    - c. A minor on active duty with the armed forces
    - d. A legally emancipated minor with documentation provided by a court of law
- B. Base Hospital contact is required for the following:
1. Any patient who presents with an altered level of consciousness to include a loss of consciousness, syncope, acute neurological symptoms (i.e., disoriented, bizarre behavior, dizzy, etc) prior to or upon arrival of EMS personnel.
  2. Any patient who has attempted suicide or verbalizes suicidal intent.
  3. A patient making a decision, which is clearly irrational in the presence of an obvious potentially life-threatening condition.
  4. A patient under a "5150 hold", which has been invoked by a person authorized to make such a "hold".
- C. Individuals who can refuse evaluation, treatment or transportation include:
1. A competent adult
  2. A competent minor patient who is able to make his/her own medical decisions (see A.2.)
  3. A competent parent or guardian on behalf of a minor
  4. The patient's designated medical decision maker to include:

- a. An individual who is designated as the "health care agent" or "attorney-in-fact" who has the legal responsibility for making the patient's medical decisions (must present evidence of Advance Health Care Directive to include written documentation of conservatorship or durable power of attorney)
  - b. The parent or legal guardian for an individual under the age of 18 who is not able to make his/her own medical decisions (see A.2.)
  - c. An individual who has a signed consent from the parent or legal guardian for medical decisions of a minor (i.e., a teacher, athletic coach, school counselor or nurse, camp counselor, etc.)
- D. Individuals who cannot refuse evaluation, treatment or transportation without first consulting with base hospital include:
1. Adults or minors who are able to make their own medical decisions but are not deemed to be competent (this may be due to illness, injury or impairment due to drugs or alcohol intoxication)
  2. Persons on 5150 hold
  3. Minor patients who are not able to make their own medical decisions
  4. Individuals who are not the patient's parent, legal guardian or designated medical decision maker (see C.4. above)
- E. If a patient refuses emergency medical evaluation, treatment, or transportation, and:
1. If the patient is deemed to be competent and able to make his/her own medical decisions, and base hospital contact is not required (see B. above), then the patient may refuse and sign release.
  2. If the patient is not competent or able to make his/her own medical decisions and base hospital contact is required, then the patient may not refuse evaluation, care or transport without first consulting with base hospital.
  3. In cases where a patient cannot refuse (see D. above), but is refusing treatment and/or transportation, EMS personnel shall consult with base hospital physician and request law enforcement assistance.
- F. Refusal of Care - Against Medical Advice: The patient, parent, legal guardian or the patient's designated medical decision maker should sign the "Release from Care" form and a Patient Care Report Form must be completed, documenting the patient's refusal of care and/or transportation, any reasons stated for such refusal, and documentation that the patient was informed of potential consequences of their refusal.
- G. Release at Scene - No Treatment/Transport Necessary: Any patient who, after a complete assessment by EMS personnel, does not appear to have a medical problem that requires immediate treatment and/or transportation, may be released at the scene.

The patient, parent, legal guardian or the patient's designated medical decision maker should sign the "Release from Care" form and a Patient Care Report Form must be completed, documenting the results of the assessment and documentation that the patient did not appear to have a medical problem that requires immediate treatment and/or transportation. Base Hospital contact is not required for a Release at Scene.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

1. Emergency Medical Services (EMS) responding personnel (public safety personnel, fire department first responders, and emergency ambulance personnel) should use this policy to determine when to institute resuscitation, and when to stop resuscitative efforts.
2. EMS responding personnel may determine obvious death but may not pronounce death. Apparent field deaths not covered by this policy require Base Hospital physician consultation for a decision not to institute, or to cease, resuscitative efforts. This consultation with the Base Hospital should be initiated with a declaration such as, "Request for Base physician to discontinue CPR for apparent death in the field."
3. In multi-casualty incidents with limited resources available, triage decisions take precedence over the following policies and procedures.
4. These criteria should not be applied in cases of suspected hypothermia or suspected drug ingestion. Those cases require full resuscitation and Base Hospital contact.
5. CATEGORY I--Obvious death
  - 5.1 Pulseless, non-breathing patients with one or more of the following:
    - Decomposition of body tissues.
    - Total decapitation, incineration, separation or destruction of the heart or brain.
    - Rigor mortis
    - Post-mortem lividity

Signs of death may be misleading. Rigor mortis can be mimicked by conditions causing increased muscle rigidity (e.g. Parkinson's disease, etc). Lividity is less reliable and requires an undressed patient. Loss of body heat is of no value in a cold environment, but has some value in a warm one. Poor hygiene may resemble "decomposition."

5.2 Procedure

5.2.1 Do not initiate CPR. Base contact is not mandatory.

5.2.2 In patients meeting "rigor mortis," "post-mortem lividity",

and "traumatic cardiac arrest" criteria the airway should be opened for a 3D-second apnea check. Pulse should be checked on central blood vessel, e.g. carotid, femoral for 30 seconds. Heart sounds and respirations should be checked with stethoscope. Pupils should be checked through reaction of pupils to bright light.

5.2.3 If fire department first responders or emergency ambulance personnel are the first on scene they must remain until the arrival of public safety personnel. A copy of PCR Form must be left with the patient for the coroner.

5.2.4 Once the determination of obvious death has been made, cancel any other EMS responding personnel. Emergency ambulance personnel do not need to be on scene for determination of obvious death. Due to radio communications lag time, emergency ambulance personnel must perform and document a full patient assessment and complete a Patient Care Report (PCR) Form.

6. CATEGORY II--Not resuscitation candidate

6.1 Pulseless, non-breathing patients with one or more of the following:

- Unwitnessed collapse (suspected >15 min without CPR) found by ALS or LALS personnel in asystole;
- Unwitnessed collapse (suspected >15 min without CPR) found by EMT-D personnel to have a non-shockable rhythm;
- Traumatic cardiac arrest. 6.2 Procedure

6.2.1 These are generally not candidates for resuscitation. Do not start CPR, unless doubt exists about length of down time, or other mitigating circumstances. May start resuscitation at your discretion.

- 6.2.2 Document complete patient history and evaluation on patient care record. Attach rhythm strip (with necessary equipment). Base contact not mandatory.

7. CATEGORY III--Failed resuscitation attempt

- 7.1 Cardiac arrest patients receiving a resuscitative effort who do not establish a potentially perfusing rhythm may be pronounced in the field after Base contact. The Base Hospital Physician will make the determination when to cease resuscitative efforts.

7.2 Procedure

- 7.2.1 Must have 1) ALS airway in place, and 2) Received appropriate ALS medications.
- 7.2.2 Notify base physician. If physician believes no further resuscitative efforts are appropriate, physician will make determination to cease resuscitative efforts.
- 7.2.3 Children and patients with persistent or recurrent ventricular fibrillation should have distance to hospital weighed against any need for further therapy.
- 7.2.4 After resuscitation ceased, support family. Do not leave family alone.
- 7.2.5 Notify investigative public safety agency.
- 7.2.6 Leave PCR, rhythm strips, other documentation for coroner.

- 8. EMS responding personnel should contact the Base Hospital for "determination of death" whenever the field application of these protocols is unclear.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

I. AUTHORITY AND REFERENCES:

*Health and Safety Code, Division 2.5, Section 1798; California Code of Regulations, Title 22, Division 5, Section 72527; Probate Code Sections 4000-4026, 4600-4643, and 4780-4786.*

II. PURPOSE:

This policy identifies the types of documents and the circumstances in which emergency response employees may withhold or withdraw resuscitative measures.

III. APPLICATION:

A. Emergency response employees shall recognize that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life sustaining treatment withheld or withdrawn.

B. This policy shall apply to individuals in a private residence or other location who have expressed a desire to avoid resuscitative measures, and to individuals in any licensed health care facility (e.g., long term health care facilities, skilled nursing facilities, hospice/other facilities).

C. Emergency response employees may withhold or withdraw resuscitative measures when presented with an acceptable DNR order, as long as it can be reasonably determined that the patient is the subject of the document or request.

D. Exception:

1. Relief of airway obstruction in a patient who is still conscious.

IV. DEFINITIONS:

A. **“Advance Health Care Directive”** or “advance directive” means a document executed pursuant to the Health Care Decisions Law. This document allows either or both of the following:

1. Appoints another person as the patient’s “health care agent” or “attorney-in-fact.”
2. The patient may write specific health care wishes.

B. **“Attorney-in-Fact”** or “health care agent” means a person granted authority to act for the person as governed by the Uniform Health Care Decisions Act (Division 4.5, commencing with Section 4670 of the Probate Code). This person has legal authority to make decisions about the named individual’s medical care.

C. **“Do-Not-Resuscitate (DNR)”** means no chest compressions, no defibrillation, no assisted ventilation, no basic airway adjuncts, no advanced airway adjuncts (endotracheal tube, Combitube), no cardiotoxic medications or other medications or means intended to initiate a heartbeat or to treat a non-perfusing rhythm.

D. **“DNR Directive”** means a DNR document or order that is:

1. An approved State of California Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) prehospital DNR request or an equivalent document from another jurisdiction.

2. DNR orders written by a physician for patients in hospices, skilled nursing facilities, or other licensed facilities.

E. **“DNR Medallion”** means a Medic Alert ® medallion/bracelet engraved with the words “do not resuscitate”, or the letters “DNR”, or “DNR-EMS”, a patient identification number, and a 24-hour toll-free telephone number issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

F. **“Emergency Response Employees”** includes firefighters, law enforcement officers, emergency medical technicians I and II, paramedics, and employees and volunteer members of legally organized and recognized volunteer organizations.

G. **“Immediate Family”** means the spouse, adult child(ren), parent of a patient, adult sibling, or domestic partner (pursuant to Section 297 of the Family Code).

#### V. GUIDELINES FOR HONORING A DO-NOT-RESUSCITATE ORDER:

A. Emergency response employees shall, at all times, respect the patient’s right to dignity and privacy. DNR patients shall receive necessary supportive care and other comfort measures.

B. The DNR order shall be disregarded if the patient requests resuscitative measures.

C. Emergency response employees shall honor a DNR request when it can be reasonably established that the patient is the subject of the DNR request, and

1. Emergency response employees have identified a DNR Directive or DNR medallion as defined elsewhere in this document, or
2. The emergency response employee has personally seen the DNR order in the patient's medical record in a licensed facility.

- a. The emergency response employee shall document on the prehospital care report (PCR) the name of the physician writing the order and the date the order was signed.

D. Emergency response employees may accept a verbal request to withhold or withdraw resuscitative measures under the following circumstances:

1. A licensed physician and surgeon, identified as the patient's physician, gives the emergency response employee a verbal order.

- a. The physician should write the DNR order on the PCR and sign the order, if possible. If not, EMS personnel should record the order.

- b. The physician's name, address, telephone number, and medical license number should also be recorded on the PCR.

2. A DNR request is communicated by an "attorney-in-fact" or "health care agent."

- a. The attorney-in-fact must specifically identify themselves as the prescribed attorney-in-fact in the written document.

- b. The attorney-in-fact should sign the PCR as the "attorney-in-fact."

3. Immediate family, present at the scene, may decline resuscitative measures on behalf of the patient.

- a. The name(s) of the immediate family who made the decision to withhold or withdraw resuscitative measures shall be documented on the PCR.

- b. The immediate family member shall sign the PCR.

E. Emergency response employees should note on the PCR that a DNR order was present and honored.

F. Base contact should be made and the Base Physician consulted and resuscitation should be initiated:

1. If there are any questions regarding validity of the DNR order, or
2. If DNR directive is incomplete or not signed, or

3. When a document other than those listed in this policy is presented to emergency response employees, or
  4. If there is a concern regarding identification of "immediate family," or
  5. If there is disagreement among family members regarding the provision or withdrawal of resuscitative measures, or
  6. Anytime emergency response employees have concerns or require assistance.
- G. DNR patients who are in cardiopulmonary arrest should not be transported. Emergency response employees will contact the local police agency and/or coroner's office. Support to family members on scene should be offered as indicated.
- H. DNR patients who decline transport to the hospital, including those patients for whom transport is declined on their behalf, should not be transported.
- I. If a DNR patient is transported to a hospital, the following shall apply:
1. A DNR order shall be honored by emergency response employees during transport of the patient.
  2. In general, a DNR patient should not be transported Code 3.
  3. The DNR order/directive should accompany the patient; the hospital should include a copy of the DNR order in the patient's hospital medical record.
- 

**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director



# EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



## PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotoxic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

## APPLICABILITY

This form was designed for use in prehospital settings -- i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

## INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decision-maker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a Durable Power of Attorney for Health Care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The **white copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion — see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **goldenrod copy** of the form should be retained by the physician and made part of the patient's permanent medical record.

The **pink copy** of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). *Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.*

## REVOCATION

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

*Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.*



# EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, \_\_\_\_\_, request limited emergency care as herein described.  
*(print patient's name)*

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

\_\_\_\_\_  
Patient/Surrogate Signature Date

\_\_\_\_\_  
Surrogate's Relationship to Patient

*By signing this form, the surrogate acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.*

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Print Name Telephone

**THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY**

## PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept by patient  
Goldenrod Copy: To be kept in patient's permanent medical record  
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

- I. Authority: Health and Safety Code, Division 2.5, Section 1798.
- II. Purpose: To establish the policy for prehospital treatment and transport of minors.
- III. Policy: The authority regarding treatment and/or transport of minor patients to receiving facilities rests with the medical director of the local EMS Agency.

A. Voluntary consent:

1. Treatment or transport of a minor child shall be with the verbal or written consent of the natural parents or court appointed guardian.

B. Involuntary consent:

1. In the absence of a natural parent or court appointed guardian, treatment and/or transport of a minor child who is unconscious or suffering from a life threatening illness or injury may be initiated without parental consent and in accordance with the laws for implied consent.
2. Treatment or transport may be authorized by a police officer who has placed a minor child in custody.
3. Treatment and/or transport of a minor child who is not unconscious or suffering from a life threatening illness or injury, where the natural parents or guardian are not present, will be under the direction of the Base Hospital Physician.

C. Transport to a receiving facility:

1. Minor children, without parents or guardian at the scene, shall be transported to the most accessible receiving or specialty care center.
2. If the minor child is not injured he/she may be released to a responsible adult (i.e. school nurse, law enforcement personnel or person of similar standing) at the scene. Release can only be authorized by the Base Hospital and an approved "medical release" must be signed by the person accepting responsibility.

3. Transport of minor children with parents/guardian at the scene or written consent for treatment from the parents/ guardian may be handled as an adult transport.
- D. See attached for applicable circumstances where parental consent is not needed for care in non-life threatening situations.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

- I. Authority: Health and Safety Code, Division 2.5. Section 1798.
  
- II. Purpose: To establish a policy for the transportation of patients by ambulance from the scene of a medical emergency to the most appropriate receiving facility.
  
- III. Policy:
  - A. Patients should be transported from the scene of the incident to the most accessible and appropriate hospital having a permit for Basic or Comprehensive, emergency medical care pursuant to California Code of Regulations, Title 22, Division 5, staffed, equipped, and prepared to administer care appropriate to the needs of the patient.
  
  - B. Transport to other than the most accessible and appropriate facility will be authorized under the following conditions:
    1. If it is in the best interest of the patient, based on the medical judgment of the Base Hospital Physician;
  
    2. If the patient meets the "competency" requirement as outlined in Policy #4130 and is over 18 years of age, an emancipated minor, a minor who is married, a minor who is in the military, a legal guardian or a parent of a minor, and the facility of preference is not beyond a "reasonable" distance from the scene of the incident.

A "reasonable" distance is based on the length of time the transporting ambulance will be out of its service area and the availability of "back-up" ambulance service.
  
  - C. In the event patient's request is unreasonable and patient is unwavering in that request, Base Hospital consultation must be obtained. Patient should be presented with alternatives for obtaining care/transport or modification of services offered.

- D. DOCUMENTATION: The EMT should ensure documentation includes patient history and assessment, a description of the patient which clearly indicates his/her decision-making capacity, why the patient selected an alternate receiving facility (other than the most accessible facility), a statement that the patient understands the risks/consequences of his/her decision, alternatives presented to the patient, and results of consultation with Base Hospital.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

EMS SYSTEM OPERATIONS

**Requests for Enroute Rendezvous  
With an ALS/LALS Emergency Ambulance**


**POLICY # 4180**

A BLS unit may request or be requested to rendezvous with an ALS/LALS emergency ambulance, if available, in accordance with the following:

- A. A request for rendezvous may be made if the patient presents with:
  - 1. Hypotension (systolic pressure < 90mm Hg)
  - 2. Airway compromise
  - 3. Unconsciousness
  - 4. If the Base Hospital physician determines that a rendezvous would benefit a patient who exhibits a life-threatening condition
- B. A request can be made directly by the BLS ambulance for situations described in A.1-3 above. The request should be made through the ICSO dispatch.
- C. ICSO will dispatch the closest, available ALS/LALS emergency ambulance. The ICSO dispatcher will notify the BLS ambulance and/or the Base Hospital of the availability and ETA of the responding ALS/LALS ambulance to the designated rendezvous location.
- D. Transport of the patient by the BLS unit should not be delayed to wait for an ALS/LALS unit.
- E. The rendezvous must be as brief as possible with the ALS/LALS provider, with any needed equipment and supplies, continuing patient care in the BLS unit.
- F. LALS units should not request a rendezvous with an ALS unit unless specifically directed to do so by the Base Hospital physician. Such a request should occur only in an unusual circumstance where the physician determines that a rendezvous would benefit a patient who exhibits a life-threatening condition.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

EMS SYSTEM OPERATIONS

**Base Hospital Physicians Orders for Intentional  
Deviation from EMT-P, EMT-II, EMT-I Protocols**

**POLICY #4190**

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- I. Authority: Health and Safety Code, Division 2.5, Section 1797.220 and 1798.
- II. Purpose: To establish the Imperial County policy and procedure for Base Hospital Physician orders for intentional deviation from ALS/LALS Treatment Protocols.
- III. Policy:
  - A. Orders for intentional deviation from ALS/LALS Treatment Protocols may be given by Base Hospital Physicians with direct voice contact with ALS/LALS providers.
    - 1. The order must be within the scope of practice of EMT-P, EMT-II, or EMT-I/Optional Skill in Imperial County.
    - 2. The order must be deemed necessary by the Base Hospital Physician to prevent serious morbidity or mortality.
  - B. ALS/LALS providers will not be subject to disciplinary action for carrying out the order, if the order is within the provider's scope of practice.

Procedure:

- A. Base Hospital Physician shall:
  - 1. Personally give the order via direct voice contact with the EMT-P, EMT-II, or EMT-I/Optional Skill.
  - 2. If the order has been carried out, remain in direct voice contact with the provider until the patient's condition is stabilized and complete "Report of Order for Intentional Deviation from ALS/LALS Protocols" and submit to Base Hospital Medical Director for review.

EMS SYSTEM OPERATIONS

**Base Hospital Physicians Orders for Intentional  
Deviation from EMT-P, EMT-II, EMT-I Protocols**

**POLICY #4190**

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- B. ALS/LALS Provider:
1. Shall receive order directly from Base Hospital Physician via direct voice contact.
  2. Shall document on Emergency Medical Services Patient Care Report form that order was received directly from Base Hospital Physician (name).
  3. Shall complete a "Report of Order for Intentional Deviation from ALS/LALS Protocols" and submit to Base Hospital Nurse Coordinator.
- C. MICN shall:
1. Not relay any order that deviates from EMT-P, EMT-II, or EMT-I/Optional Skill Treatment Protocols.
  2. Inform Base Hospital Physician that order is deviation from EMT-P, EMT-II, or EMT-I/Optional Skill Treatment Protocols.
  3. Inform Base Hospital Physician that he/she must personally give order via direct voice contact with ALS/LALS provider.
  4. Report deviation in writing to Base Hospital Nurse Coordinator/ designee within twenty-four (24) hours of occurrence of incident.
- D. Base Hospital Nurse coordinator shall gather all pertinent data relevant to incident and forward to Base Hospital Medical Director and EMS Medical Director review.
- E. Base Hospital Medical Director shall review incident, complete "Report of Orders for Intentional Deviation from ALS/LALS Protocols," and submit a written report to Imperial County EMS Medical Director within ten (10) days of incident.
-

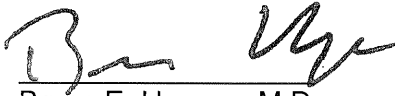
EMS SYSTEM OPERATIONS

**Base Hospital Physicians Orders for Intentional  
Deviation from EMT-P, EMT-II, EMT-I Protocols**

**POLICY #4190**

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

**REPORT OF:  
ORDER FOR INTENTIONAL DEVIATION FROM PROTOCOLS**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Run Number: \_\_\_\_\_

FIELD PROVIDER: \_\_\_\_\_ TITLE: \_\_\_\_\_

MICN: \_\_\_\_\_ BASE HOSPITAL PHYSICIAN: \_\_\_\_\_

*Field Provider's report of incident:*

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Reporting person and title \_\_\_\_\_ Date: \_\_\_\_\_

*Base hospital physician's report of incident:*

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Reporting person and title: \_\_\_\_\_ Date: \_\_\_\_\_

REVIEW OF INCIDENT:

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Base Hospital Medical Director: \_\_\_\_\_ Date: \_\_\_\_\_

- I. Authority: Health and Safety code, Division 2.5, Section 1798 and; child abuse: California Penal Code, Article 2.5; and, Elder Abuse: Chapter 1273, Statutes of 1983, SB 1210, Sections 9381(a) and 9382. Welfare and Institutions Code Chapter II, Part 3, Division 9.
- II. Purpose: To establish a policy for identification and reporting of incidents of suspected child or elder abuse.
- III. Policy: All Imperial County pre-hospital care personnel are responsible for reporting incidents of suspected abusive behavior toward children, dependent adults and elders.

IV. Reporting Procedure:

A. Child Abuse:

1. Suspicion is to be reported by telephone to the local police department or sheriff's office, as soon as possible. Be prepared to give the following information:
  - a. Name of person making report;
  - b. Name of child;
  - c. Present location of the child;
  - d. Nature and extent of the injury;
  - e. Information that led reporting person to suspect Child abuse; and,
  - f. Other information as requested.
2. Phone report must be followed within thirty-six (36) hours by a written report on "Suspected Child Abuse Report" form #SS8572 (see attached).
3. The identity of all persons who report under this article shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protective agency, or to the district attorney in a criminal prosecution or by court order.

- B. Dependent Adult and Elder Abuse:
1. Suspicion should be reported as soon as possible by telephone to the local police department or sheriff's office. Be prepared to give the following information:
    - a. Name of person making report;
    - b. Name, address, and age of the adult or elder;
    - c. Nature and extent of person's condition; and,
    - d. Other information, including information that led the person to suspect abuse.
  2. Telephone report must be followed by a written report within thirty-six (36) hours using "Report of Suspected Elder Abuse" form #04-5 DSS (see attached).
  3. The identity of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.
- C. When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of child or elder 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 report may be made and signed by such 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 such report.
- D. The reporting duties are individual, and no supervisor, administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided they are not inconsistent with the provisions in this article.

V. Definitions:

Refer to attached copies of Authority.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

# SUSPECTED CHILD ABUSE REPORT (11166 PC)

TO BE COMPLETED BY REPORTING PARTY

**CASE IDENTIFICATION**

TO BE COMPLETED BY INVESTIGATING CPA

VICTIM NAME: \_\_\_\_\_

REPORT NO./CASE NAME: \_\_\_\_\_

DATE OF REPORT: \_\_\_\_\_

REPORTING PARTY

NAME/TITLE \_\_\_\_\_

ADDRESS \_\_\_\_\_

( ) \_\_\_\_\_

PHONE \_\_\_\_\_ DATE OF REPORT \_\_\_\_\_ SIGNATURE OF REPORTING PARTY \_\_\_\_\_

REPORT SENT TO

POLICE DEPARTMENT     SHERIFF'S OFFICE     COUNTY WELFARE     COUNTY PROBATION

AGENCY \_\_\_\_\_ ADDRESS \_\_\_\_\_

OFFICIAL CONTACTED \_\_\_\_\_ ( ) \_\_\_\_\_ DATE/TIME \_\_\_\_\_

VICTIM

NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_ ADDRESS \_\_\_\_\_ BIRTHDATE SEX RACE \_\_\_\_\_

PRESENT LOCATION OF CHILD \_\_\_\_\_ ( ) \_\_\_\_\_ PHONE \_\_\_\_\_

SIBLINGS

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____
NAME BIRTHDATE SEX RACE	NAME BIRTHDATE SEX RACE

SUSPECTS

NAME (LAST, FIRST, MIDDLE) BIRTHDATE SEX RACE	NAME (LAST, FIRST, MIDDLE) BIRTHDATE SEX RACE
ADDRESS _____	ADDRESS _____
( ) HOME PHONE ( ) BUSINESS PHONE	( ) HOME PHONE ( ) BUSINESS PHONE

INCIDENT INFORMATION

*IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS CIRCLE.*

1. DATE/TIME OF INCIDENT \_\_\_\_\_ PLACE OF INCIDENT \_\_\_\_\_ (CHECK ONE)  OCCURRED  OBSERVED

IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:

GROUP HOME OR INSTITUTION     FOSTER CARE     OTHER PLACEMENT (SPECIFY \_\_\_\_\_)

2. TYPE OF ABUSE: (CHECK ONE OR MORE)  PHYSICAL     MENTAL     SEXUAL ASSAULT     NEGLECT     OTHER

3. NARRATIVE DESCRIPTION: \_\_\_\_\_

4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED: \_\_\_\_\_

5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD: \_\_\_\_\_

REPORT OF SUSPECTED ABUSE

SUBMIT REPORT WITHIN 36 HOURS OF THE TELEPHONE REPORT TO YOUR LOCAL ADULT PROTECTIVE AGENCY

Section 1273, Statutes of 1983 - SB1210  
Sections 9381(a) and 9382 and Chapter 11  
Part 3 of Division 9 of W and I Codes)

NOTE: INSTRUCTIONS ON REVERSE

FOR USE BY INVESTIGATING AGENCY	
VICTIM NAME:	
SUSPECTED ABUSER NAME:	
REPORT NUMBER/CASE NAME:	
DATE OF REPORT:	

TO BE COMPLETED BY REPORTING PARTY (PLEASE PRINT OR TYPE)

A. REPORTING PARTY

NAME/TITLE OF REPORTING PARTY:		SIGNATURE OF REPORTING PARTY:	DATE OF WRITTEN REPORT:
ADDRESS/STREET:		CITY:	TELEPHONE: ( )

B. REPORT MADE TO

ADULT PROTECTIVE AGENCY:		ADDRESS/STREET:	
OFFICIAL CONTACTED:	TELEPHONE: ( )	DATE/TIME OF TELEPHONE REPORT:	
CAL LAW ENFORCEMENT OR OTHER AGENCY CONTACTED (IF DIFFERENT FROM "OFFICIAL CONTACTED"):	TELEPHONE: ( )	DATE/TIME OF TELEPHONE REPORT:	

C. VICTIM

NAME (LAST NAME FIRST):		AGE:	SEX:	RACE:
ADDRESS/STREET:		TELEPHONE: ( )		
PRESENT ADDRESS/STREET OF ADULT (if different from above):		CITY:	TELEPHONE: ( )	

D. INCIDENT INFORMATION

DATE/TIME OF INCIDENT:	PLACE OF INCIDENT:	LEARNED OF INCIDENT BY: (CHECK ONE) <input type="checkbox"/> VERBAL REPORT <input type="checkbox"/> OBSERVATION
INCIDENT OCCURRED IN AN OUT-OF-HOME CARE SETTING, CHECK TYPE OF CARE: <input type="checkbox"/> BOARD AND CARE <input type="checkbox"/> SKILLED NURSING FACILITY <input type="checkbox"/> OTHER PLACEMENT (SPECIFY):-----		
TYPE OF PHYSICAL ABUSE (CHECK ALL THAT APPLY): <input type="checkbox"/> BEATING <input type="checkbox"/> CONSTRAINT <input type="checkbox"/> SEXUAL <input type="checkbox"/> DEPRIVATION <input type="checkbox"/> OTHER (SPECIFY):-----		
OTHER TYPE OF ABUSE: <input type="checkbox"/> FIDUCIARY <input type="checkbox"/> NEGLECT <input type="checkbox"/> ABANDONMENT <input type="checkbox"/> EMOTIONAL <input type="checkbox"/> OTHER (SPECIFY):-----		

E. COMMENTS


Please provide a brief narrative about any entries that you believe require explanation or clarification. Also add any additional information not requested above that you believe pertinent to the incident of physical abuse (e. g., what the victim said, known history of similar incidents for this adult, etc.).

- I. Authority: Health and Safety Code, Sections 1797.170, 1798, 1798.2, 1798.102. -
- II. Purpose: To establish Imperial County policy for patient transfer after treatment by a non-transporting EMT-1, Advanced EMT, EMT-II, EMT-P Unit.
- III. Policy:
  - A. Non-transport EMT-1.
    1. Patient assessed and/or treated with EMT-1 skills only.
      - a. Patient may be transported by EMT-1 or higher level ambulance.
      - b. Non-transport EMT-1 must give verbal report to transporting EMT.
      - c. Non-transport EMT-1 may be released at the scene.
      - d. Written Patient Care Report by non-transporting EMT-1 not required.
    2. Patient defibrillated by non-transport EMT-I.
      - a. Patient may be transported by EMT-1 or higher level ambulance.
        - 1) Non-transport EMT-1 must give verbal report to transporting EMT.
        - 2) Non-transport EMT-1 may be released at the scene.
        - 3) Non-transport EMT-1 must complete a Patient Care Report.
  - B. Non-transport Advanced EMT, EMT-II, EMT-P
    1. Patient assesses and/or treated with EMT-1 skills only.
      - a. Patient may be transported by EMT-1 or higher level ambulance.
      - b. Advanced EMT, EMT-II, EMT-P must give verbal report to transporting EMT but need not accompany patient unless requested by Base Hospital (must contact Base Hospital for permission to release patient to lower level care provider).

- c. Written Patient Care Report by non-transporting EMT not required.
2. Patient treated with ALS/LALS skills or medications.
  - a. Patient may be transported by EMT-1 or higher level ambulance.
    - 1) If EMT-1 ambulance, the Base Hospital physician may release the non-transport Advanced EMT, EMT-II, EMT-P at the scene if;
      - a) The patient is non-critical and deemed stable for transport by EMT-1 ambulance.
      - b) The only ALS/LALS skill performed was establishing a peripheral intravenous line.
      - c) The EMT-1 may only monitor, maintain a present rate of flow or turn off the IV fluid.
  - b. EMT with highest level of certification will continue care at scene and enroute to hospital.
    - 1) If non-transport EMT and ambulance EMT have equal certification, ambulance EMT will assume patient care unless requested otherwise by the Base Hospital.
    - 2) Non-transport Advanced EMT, EMT-II, EMT-P must complete a Patient Care Report.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

Authority: Health & Safety Code 1797.220,1798. California Code of Regulations, Title 13, Section 11 05(c).

Purpose: Define procedure for hospital emergency departments to request bypass of ambulance patients when the department is so congested additional patients may not be cared for safely. The goal of this policy is to minimize bypass. Hospitals are expected to have plans for dealing with unexpected or expected large loads of patients, creating situations where the department is not appropriately staffed or equipped to care for additional patients.

Policy: A hospital emergency department may request bypass of patients for the following reasons and using the following terminology:

1. "Closed -ED Saturation" -Emergency Department resources are fully committed and not available for additional patients despite efforts by the hospital to accommodate peak loads.
2. "Closed -Internal Disruption" -The hospital cannot receive any patients due to a physical plant emergency (e.g. fire, power outage, etc.).
3. "Closed -CT down" -The hospital's CT scanner is out of service, and the patient requires an emergency CT to determine management; e.g., unconscious following head trauma, suspicion of operative intracranial lesion, acute ischemic stroke with consideration of thrombolytic therapy, etc."

Final authority for patient destination rests with the base hospital physician.

Patients with uncontrollable problems in the field (e.g. unmanageable airway, uncontrolled hemorrhage, cardiac arrest) will be transported to the most accessible receiving center.

If all receiving hospitals are on bypass, then patients will go to the nearest hospital.

Procedure: The decision to go on bypass must be made by both the emergency department physician and the charge nurse. To go on bypass status, the emergency department must notify the base hospital and the appropriate ambulance dispatch center (either the Imperial County Sheriffs Office at 339-6311 and/or the Calexico Police Department at 768-2140). The dispatch center will notify ambulance providers. The hospital must indicate the category of bypass and the expected duration of bypass.

Hospitals on bypass shall immediately notify the base hospital and the dispatch center when bypass is no longer necessary.

The emergency department shall maintain a written log indicating, at a minimum, the names of the individuals who authorized the bypass, dates, times and category for which the department was closed. A copy of this log shall be sent to the EMS Agency the first of each month.

Hospital administration shall also be notified of activation of bypass status.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

EMS SYSTEM OPERATIONS

**EMT-Paramedic Interfacility Transport of Patients  
with IV Nitroglycerin/Heparin Infusions**

**POLICY #4230**

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This policy defines the procedure for interfacility transfers by paramedics for patients with intravenous (IV) nitroglycerin and/or heparin infusions.

1. The paramedic shall receive orders from the transferring physician prior to leaving the sending hospital. These orders shall be documented in writing as directed by the transferring physician. The written order must include the medication, solution, concentration, and rate of infusion for the IV fluids.
2. The transferring physician, or designee, shall provide the paramedic with verbal report and written documentation regarding the care provided to the patient. This documentation shall be reviewed by the paramedic prior to the transfer.
3. The name of the receiving hospital and the name of the receiving physician who has accepted the patient shall be provided in the transfer documents.
4. The paramedic shall monitor the patient during transport and shall document the ongoing assessment on the Patient Care Report Form approved by the EMS medical director.
5. Only designated paramedics who have completed the approved training may monitor the following IV infusions during transports:

Nitroglycerin 50 mg/250cc D5W

Heparin 25,000 u/250cc or 500cc D5W

6. The paramedic shall follow the directions of the transferring physician. If it is anticipated that additional medication orders (e.g. morphine) may be needed to stabilize the patient's condition during transport, these orders must be within the paramedic's scope of practice and documented in writing as standing orders signed by the physician prior to leaving the sending facility.
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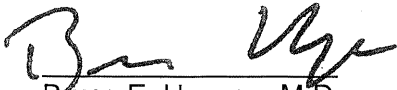
EMS SYSTEM OPERATIONS

**EMT-Paramedic Interfacility Transport of Patients  
with IV Nitroglycerin/Heparin Infusions**

**POLICY #4230**

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

I. Authority:

Division 2.5 Health and Safety Code, Sections 1797.178 and 1798; Title 22 California Code of Regulations, Division 9, Chapter 8.

II. Purpose:

To establish Imperial County policy for requesting air ambulance services in the pre-hospital setting.

III. Definitions:

**Air Ambulance.**

"Air ambulance" means any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support. Air Ambulance includes EMS helicopters and EMS fixed-wing aircraft.

**Rescue Aircraft.**

"Rescue aircraft" means an aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

IV. Policy:

A. Determination of need for EMS helicopter:

First Responders (rescue, fire, law enforcement) and EMS personnel may request EMS helicopter response. Before dispatching an EMS helicopter, on-scene personnel should take into account the medical condition of the patient(s), the medical necessity for air transport, access to a landing site, and the safety of air and ground personnel. EMS helicopter should only be requested by the on-scene Incident Commander, or designee, and only when the benefits outweigh the risks.

1. The Imperial County Sheriffs Department (ICSD) Dispatch Center may dispatch an EMS helicopter for a report received from another PSAP, witnesses or first responders of any of the following:
  - a. Victim is located in an area which is inaccessible to ground ambulance;
  - b. Ground transport may aggravate patient's injuries due to rough (off-road) terrain;
  - c. Any patient who appears to meet critical trauma criteria, regardless of location or proximity to nearest hospital. For example, this could include

a report of a victim involved in a vehicle crash that is unconscious, or appears to have multiple fractures or difficulty breathing.

2. An EMS helicopter may be placed on "standby" status under the following conditions:
  - a. Based on initial report from ICSD dispatch, responding agencies may request an EMS helicopter be placed on "standby" status to prepare for the quickest possible response in the event they are needed.
  - b. ICSD dispatch center may at any time place an EMS helicopter on "standby" status when the patient(s) condition is unknown and either of the following situations exist:
    1. Prolonged response time to the scene for ground ambulance (>30 minutes)
    2. Delayed scene time due to extrication or other unusual scene conditions and combined scene and ground travel time is >30 minutes.

**B. Dispatch Guidelines:**

1. Single Point of Contact:

A single point of contact for dispatch of EMS helicopters is essential to ensure appropriate and efficient use of these resources. First responder, law enforcement, EMS personnel, and other PSAPs should not contact EMS helicopters directly (with the exception of the local CHP and CHP Air Operations). The ICSD is the designated PSAP in Imperial County for dispatching EMS helicopters. CHP dispatch should notify ICSD as soon as possible whenever the CHP helicopter has been dispatched to a medical emergency in Imperial County.

2. Information to be provided to dispatch:

First responder, law enforcement, EMS personnel, and other PSAPs should provide the following information when requesting an EMS helicopter:

- Type of incident (vehicle rollover, multi-vehicle collision, etc)
- Location of Incident (GPS if available)
- Approximate number of patients
- Approximate age, weight and condition of patient(s) if known
- Special scene conditions (terrain, winds, hazards, power lines, etc)
- Location of landing site for helicopter
- Ground contact and radio frequency

3. Ground Ambulance:

Ground ambulance (ALS or BLS) should always be dispatched concurrently with an EMS helicopter, or continue response to the scene as directed. The dispatch of an EMS helicopter should not preclude the dispatch or continued

response of a ground ambulance. Dispatch shall inform the responding ground ambulance that an EMS helicopter has also been dispatched. Ground ambulance crew should be informed of which EMS helicopter provider has been dispatched and their ETA to the scene. The EMS helicopter provider should also be informed of which ground ambulance provider is responding and their ETA to the scene.

4. Selection of EMS Helicopter Provider:

ICSD Dispatch will alert an EMS helicopter provider, authorized by the local EMS Agency to provide air transport services in Imperial County, which is capable of completing the mission. ICSD should initially attempt to alert a private provider of the need for air transport services, and if none available, dispatch a public or military provider. If multiple private EMS helicopter providers are authorized to provide service in Imperial County, then ICSD should attempt to dispatch providers based on their proximity and response time to the scene. If there are multiple locally based providers, then ICSD should attempt to dispatch on a rotational basis. If an EMS helicopter is not available or is unable to complete the mission due to unusual terrain or other conditions, it is appropriate for ICSD to dispatch a Rescue Aircraft (MCAS/SAR, CHP, Border Patrol, etc).

(Note: Any EMS Helicopter Service Provider authorized to operate in Imperial County shall notify the ICSD Dispatch Center whenever they will be unable to respond to calls due to maintenance, staffing, or other reasons excluding weather, when such period of inability to respond is expected to exceed 12 hours.)

5. Cancellation policy:

- a. The ground ambulance crew may only cancel a responding EMS helicopter under the following conditions:
  - It is determined that ground ambulance is more appropriate after consultation with the base hospital;
  - Ambulance personnel consult with base hospital regarding patient's refusal of medical care or transportation, and base hospital concurs with cancellation of EMS helicopter.
- b. The EMS helicopter may only cancel a responding ground ambulance if the air team determines they can transport the patient(s) before the ground ambulance arrives.

C. Rendezvous with EMS Helicopter:

If the responding EMS helicopter has a delayed response to the scene, the ground ambulance should consult with the base hospital concerning the decision to begin transport to the nearest, appropriate hospital, or to a pre-designated rendezvous

site with the EMS helicopter (including rendezvous at a local airport).

**D. Patient Destination:**

1. The determination of patient destination should be made in accordance with patient's preference, triage criteria, safety, weather, fuel availability, and other appropriate factors.
2. Patients will only be transported by air to hospitals that have an FAA approved helipad, unless it is determined that an emergency landing is necessary at an alternate site.

**E. Patient Care Guidelines:**

Medical personnel responding with an EMS helicopter shall operate under the patient care policies, procedures, and protocols established by their base medical control and/or their county of origin, subject to approval by local EMS Medical Director.

**F. Continuous Quality Improvement:**

Imperial County policies for CQI apply to all patient transports (both air and ground) originating within the county. Individual cases, providers and system issues may be audited upon receipt of an Incident Report in accordance with Policy #1200 or at the request of the local EMS Agency.

**G. Withdrawal from Operations:**

Imperial County EMS reserves the right to suspend, place on probation or restrict air ambulance services for cause, following an investigation and establishment of a practice that is outside the parameters set in this policy.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

ADMINISTRATION

**Ambulance Personal Protective Equipment**

**POLICY #4250**

**PURPOSE:**

All ambulance services, both emergency and non-emergency, must be integrated into the disaster medical response system. Through acceptance of the ambulance personal protective equipment (PPE), the ambulance providers agree, through a contract or Memorandum of Understanding (MOU) with the Imperial County EMS Agency, to participate in state and local disaster response or a declared emergency. In responding to any incident, it is the responsibility of all personnel to check in with the Incident Commander to determine appropriate levels of PPE.

Adherence to the PPE policy will ensure safety, readiness, and the ability to meet the requirements of an "all hazards" disaster response. This is consistent with the premise that ambulance personnel should not respond to an incident requiring PPE beyond their level of provision and training without adhering to published standards.

The Imperial County EMS Agency has, through a grant from the California EMS Authority, procured Ambulance PPE in accordance with EMSA guidelines #216. All usage of this PPE is subject to the following terms and conditions.

**POLICY:**

Every person working on an ambulance (public or private, emergency or non-emergency, ALS or BLS) shall have available PPE consistent with this policy.

**AUTHORITY:**

Health and Safety Code 1797.220, 1798, and EMSA Guidelines #216, SB 409 (Chapter 26, Statutes of 2006).

**PROCEDURE:**

1. Availability and Specifications: The following equipment shall be available on every ambulance within the jurisdiction for all agencies including public and private, and emergency and non-emergency services.

Minimum Personal Protective Equipment (PPE)  
EMSA Guidelines #216 (revised)

REQUIRED ITEM	SPECIFICATIONS
Head	
Rescue Helmet (Work Helmet)	NFPA 1951, Blue Color
Eye Protection, Work goggles	NFPA 1999, EMS Standards
Eye Protection, glasses	NFPA 1999, EMS Standards
Body	

ADMINISTRATION

**Ambulance Personal Protective Equipment**

**POLICY #4250**

Jacket, full length - EMS, with reflective stripes	NFPA 1999, EMS Standards
Garment (single use)	NFPA 1999, EMS Standards "White Tyvek"
Hands	
Gloves - Work(Multiple use, Leather)	NFPA 1999, Physical protection
Feet	
Footwear, Personal (Multi-use, Safety)	NFPA 1999 EMS Standards: <ul style="list-style-type: none"> <li>• Height: min. 4"</li> <li>• Cut, puncture, &amp; abrasion resistant</li> <li>• Toe safety</li> <li>• Barrier protection</li> </ul>
Footwear covers, single use	NFPA 1999 OSHA: chemical resistant
Respiratory	
N-100 Mask, or N-95 Mask	
APR, Full-Face Respiratory Protection Mask (N95), or Level "C" or Escape Hood (NIOSH)	Fit-Testing Program Required
Routine Equipment	
Personal communication device	Radio, on appropriate frequency

\* NFPA - National Fire Protection Administration Standards (Standard Number)

2. Maintenance: All equipment shall be maintained in a ready-to-use state and shall be used in accordance with policy. Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition.
3. Training: Prior to usage all personnel who may be required to utilize PPE shall receive necessary training in the usage of equipment in accordance with OSHA requirements [ref. 29 CFR 1910.132(f)]. The employer shall provide training to each employee who is required by this section to use PPE. Each such employee shall be trained to know at least the following:
  - a. When PPE is necessary; what PPE is necessary; how to properly don, doff, adjust, and wear PPE; the limitations of the PPE; and the proper care, maintenance, useful life and disposal of the PPE [ref. 29 CFR 1910.132 (f)(1)(i - v)].
  - b. Each affected employee shall demonstrate an understanding of the training specified in [ref. 29 CFR 1910.132 (f)(1)] of this section, and the ability to use PPE properly, before being allowed to perform work requiring the use of PPE [ref. 29 CFR 1910.132 (f)(2)].

- c. When the employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required by [ref. 29 CFR 1910.132 (f)(2)] of this section, the employer shall retrain each such employee. Circumstances where retraining is required include, but are not limited to, situations where changes in the workplace render previous training obsolete; changes in the types of PPE to be used render previous training obsolete; or inadequacies in an affected employee's knowledge or use of assigned PPE indicate that the employee has not retained the requisite understanding or skill [ref. 29 CFR 1910.132 (f)(3)].
  - d. The employer shall verify that each affected employee has received and understood the required training through a written certification that contains the name of each employee trained, the date(s) of training, and that identifies the subject of the certification.
  - e. The employer shall ensure proper fit testing for any respiratory protection in accordance with OSHA requirements (ref. 29 CFR 1910.134). In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use.
4. Procedures Required: The employer shall include in the program the following provisions of this section, as applicable:
- Procedures for selecting respirators for use in the workplace;
  - Medical evaluations of employees required to use respirators;
  - Fit testing procedures for tight-fitting respirators;
  - Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations;
  - Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators;
  - Procedures to ensure adequate air quality, quantity, and flow of breathing air for atmosphere-supplying respirators;
  - Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations;
  - Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance.
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ADMINISTRATION

**Ambulance Personal Protective Equipment**

**POLICY #4250**

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

MEDICAL PROCEDURES

**ENDOTRACHEAL INTUBATION (ADULT)**

**POLICY #7100**

**PREPARATION OF PATIENT:**

Remove or suction any foreign materials in patient's mouth.

Ventilate the patient with 100% oxygen for a minimum of 60 seconds.

Position the patient in the "sniffing" position with the neck flexed and the head extended.

Traumatic arrest.

– No apparent **C-spine** injuries: position the patient in the "sniffing" position with the neck flexed and the head extended.

– Suspected **C-spine injury**: an assistant will provide in-line stabilization in the neutral position.

Stop ventilations and compressions.

**PROCEDURE:**

Visualize the vocal cords, using appropriate technique for selected laryngoscope blade.

Repeat suction as necessary; remove foreign bodies with Magill forceps.

Maintain visualization of the vocal cords and insert the tube into the trachea until the cuff is situated just below the vocal cords.

– Cricoid pressure may assist with visualization of the cords. It may also assist with the control of regurgitation by occluding the esophagus.

– Intubation may be attempted a maximum of three times.

– The patient should be ventilated between each attempt.

– Each attempt may take no longer than 30 seconds.

Remove the laryngoscope and stylet.

Hold the tube in the correct position (approximately 22 cm mark at the teeth) by grasping it firmly in one hand. The tube is to be secured in this position.

Inflate the cuff with 10 ml air.

Ventilate the patient with 100% O<sub>2</sub> by means of a bag valve breathing device or 40 L/min resuscitator.

To evaluate tube placement:

– Observe for bilateral rise and fall of the chest.

– Auscultate breath sounds bilaterally and over the stomach.

Connect the Toomey syringe (esophageal detector device) to the endotracheal tube and exert steady pressure. Withdraw 30 cc of air.

– If no resistance, tube is in the trachea.

– Resistance to suction or rebound down toward or to zero mark after release of syringe plunger indicates esophageal intubation.

If tube is in trachea, proceed with ventilation.

If the tube is in the esophagus, remove and begin procedure again.

Insert an oropharyngeal airway or bite block if required.

Secure the tube in place at about the 22 cm mark at the teeth by use of an ET tube holder and/or tape.

Reassess the tube position frequently during the call, each time the patient is moved or the tube is manipulated.

– Observe continuously for bilateral rise and fall of the chest.

– Auscultate breath sounds bilaterally and over the stomach.

– Check the centimeter marking at the level of the incisors and compare with initial marking.

– Test placement of tube with esophageal detector device.

**DOCUMENTATION:**

Documentation shall include:

Bilateral breath sounds after insertion.

Verification that esophageal detector device indicated tracheal position.

Size of ET tube.

MEDICAL PROCEDURES

**ENDOTRACHEAL INTUBATION (ADULT)**

**POLICY #7100**

Certification # of medic inserting tube.  
Time of insertion.  
Number of attempts required.  
Any procedural problems or complications.

**PROBLEM SOLVING:**

**Mainstem Bronchus Intubation:**

- Breath sounds decreased or absent on the one side (usually left).
  - Withdraw the tube 1 cm.
  - Auscultate bilateral breath sounds.
  - Repeat until breath sounds are equal bilaterally or until the 22 cm marking on the tube is at the level of the incisors.
  - Secure the tube.

**Esophageal Intubation:**

- Bilaterally diminished or absent breath sounds, failure of the chest to rise and fall, abdominal rise and fall with ventilation, abdominal distention, or epigastric sounds with each ventilation, strongly suggest esophageal intubation.

**NOTE: Any or all of these signs may be absent, especially in the frail and elderly patient.**

Extubate immediately and ventilate with 100% oxygen.  
Consider re-intubation with either ET tube or Combitube.

**Dislodgement:**

- Diminished or absent breath sounds, absence of chest excursion.
  - Extubate immediately and ventilate with 100% oxygen.
  - Properly secure the tube with an ET tube holder and/or tape to prevent dislodgement.
  - Disconnect the ventilation device whenever it is necessary to interrupt ventilations - i.e.: defibrillation, cardioversion, transfer of patient to gurney, ambulance, etc. to prevent dislodgement.
  - When moving the patient, manually secure ET tube.

**Emesis:**

Suction.  
Consider placement of a Combitube for large amounts of passive regurgitation.

**EXTUBATION:**

**Indications:**

- Failure to ventilate, including:
  - Failure of the chest to rise.
  - Absent breath sounds bilaterally or abdominal distention without breath sounds.
  - Esophageal intubation.
  - Malfunctioning equipment (i.e.: cuff leak).
- Patient actively resisting and/or gagging on tube (SO)

**Procedure:**

- Suction oropharynx.
- Oxygenate the patient.
- Turn the patient's head or log roll entire body to the side.
- Be prepared to suction; anticipate emesis.
- Deflate the cuff.
- Withdraw the tube on exhalation.
- Monitor patient's respiratory status and intervene as necessary.
- Provide supplemental oxygen.

MEDICAL PROCEDURES

**ENDOTRACHEAL INTUBATION (ADULT)**

**POLICY #7100**

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**APPROVAL:**



Bruce Haynes, M.D.  
EMS Medical Director

MEDICAL PROCEDURES

**ADMINISTRATION OF ENDOTRACHEAL MEDICATIONS**

**POLICY #7110**

**INDICATIONS:**

The following medications may be instilled directly into an endotracheal tube prior to or when unable to establish IV access:

Atropine  
Epinephrine  
Lidocaine

**PROCEDURE:**

Ventilate several times.

Stop CPR.

Administer drug by inserting needle of prefilled syringe into ET opening and injecting appropriate amount into tube. **NOTE: If not permanently attached to syringe, needle must be removed from the syringe prior to instilling any medication into the ET tube.**

Utilize doses in accordance with Treatment Protocols.

Adult: dose: use a volume of approximately 10 ml for each drug administration.

Total volume of all endotracheal medications for adults should not exceed 30 ml.

Mix volume of medication with adult normal saline to reach suggested volumes.

Pediatrics: Refer to Pediatric Drug Guide for correct amount to administer via ETT.

Momentarily occlude ET tube with finger while reattaching O2 source to prevent medication from being expelled by residual air in lungs.

Reattach bag and ventilate forcefully 5 times to disperse drug.

Resume CPR (entire process should take less than 10 seconds).

**APPROVAL:**



**Bruce Haynes, M.D.**  
**EMS Medical Director**

I) PURPOSE:

To define the indications and use of intranasal medication administration in the prehospital setting by Paramedics and AEMT personnel.

II) INDICATIONS:

- A) Poisoning – Narcotic Overdose
  - 1) Indicated for patients who are unconscious/unresponsive in whom an opiate overdose is suspected without IV access who require urgent medication administration
- B) Altered neurologic function - Seizures
  - 1) Indicated for patients who are actively seizing without IV access who require urgent medication administration
- C) Behavioral emergencies – For patients exhibiting severe agitation
  - 1) Indicated for severely agitated patients who require urgent medication administration to reduce the risk of injury to patient or others

III) CONTRAINDICATIONS:

- A) Epistaxis
- B) Nasal trauma
- C) Nasal septal abnormalities
- D) Nasal congestion or discharge

III) APPROVED MEDICATIONS FOR INTRANASAL ROUTE:

- A) Glucagon
- B) Naloxone (Narcan)
- C) Midazolam (Versed) – 5 mg/ml concentration required

IV) PROCEDURE:

- A) Determine appropriate medication dose per protocol
- B) Draw up medication into a syringe using appropriate transfer needle
- C) Purge air from syringe
- D) Place mucosal atomization device on the end of the syringe and screw into place
- E) Gently insert the atomizer into the nare. Stop once resistance is met
- F) Rapidly administer the medication when patient fully exhales and before inhalation.  
**ADMINISTER ½ DOSE IN EACH NOSTRIL**
- G) Do not exceed 1.0 ml per nostril

MEDICAL PROCEDURES

**INTRANASAL MEDICATION ADMINISTRATION**

**POLICY# 7120**

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- H) Monitor ECG, Vital Signs (BP, HR, RR, SPO<sub>2</sub>)
  - I) Evaluate the effectiveness of the medication, if the desired effect has not been achieved, consider repeating and/or changing route of administration
  
  - V) PRECAUTIONS:
    - A) Nasal administration does not always work for every patient
    - B) Nasal administration is less likely to be effective if the patient has been abusing inhaled vasoconstrictors such as cocaine
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**APPROVAL**



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Bruce E. Haynes, M.D.  
EMS Medical Director

PROCEDURES

**DEFIBRILLATION**

**POLICY #7200**

DEFIBRILLATION

**INDICATIONS:**

- Ventricular fibrillation.
- Pulseless ventricular tachycardia

**PROCEDURE:**

- Apply conductive gel or defibrillator pads
- Select energy level.

Monophasic	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup> /subsequent
Adult:	Max (360) J	Max (360) J	Max (360) J
Pediatric:	2 J/Kg	4 J/Kg	4 J/Kg
*Biphasic	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup> /subsequent
Adult:	*200 J	*200 J	*200 J
Pediatric:	2 J/Kg	4 J/Kg	4 J/Kg

- Press the charge button to energize the paddles.
- Clear all personnel from patient contact. Call out, "All Clear" and confirm that no one is in contact with the patient (discontinue ventilations and remove oxygen during defibrillation)
- Place the paddles on the chest (right sternal border and left lower chest @ anterior axillary line). The anterior / posterior placement should be used for obese patients
- Exert firm pressure on the paddles while simultaneously depressing the paddle buttons.
- Immediately resume CPR for 2 minutes
- Assess patient for any change in rhythm, check pulse for potentially perfusing rhythm

**NOTES:**

- **\*Follow manufacturer's recommendations.** If none listed, utilize energy levels as noted above.
- Documentation should indicate if monophasic or biphasic energy was used and the amount of Joules administered.
- Count first responder countershock/AED use/ Public access defibrillation as part of the ALS algorithm.
- During transfer of care between two different types of defibrillators (monophasic or biphasic), providers should restart with the energy level prescribed in the defibrillation protocol for their type of equipment.
- When defibrillating pediatric patients:
  - Pediatrics less than 1 year/10 Kg weight: use "infant" paddles on patient.
  - Pediatrics ≥ 1 year/10 Kg: use anterior/posterior paddle or pads placement.
- Safety Concerns – do not defibrillate patient in water; remove NTG patch prior to defibrillation; paddles should be placed 5 inches from any pacemaker or implanted defibrillator.

Approved:



Bruce Haynes, M.D.  
 EMS Medical Director

## Automated External Defibrillation (AED)

**POLICY # 7210**

These standing orders are for cardiac arrest patients age one year or greater. Large pads can be applied front and back as necessary. (excluding penetrating trauma to the head, neck, or trunk).

### I. One Shock Programmed Device:

- a. Determine patient to be unconscious, pulseless, and with absent or agonal respirations.
- b. Initiate CPR x 2 minutes (unwitnessed arrest); ventilate with 100% oxygen if possible. Witnessed arrest (by AED Provider): CPR until AED ready.
- c. Turn on Automatic External Defibrillator (AED), attach appropriate defibrillator pads; press analyze. (If the AED is equipped with a recording device, record patient incident scenario as soon as possible.)
- d. When ready (witnessed) or after 2 minutes CPR completed (unwitnessed), announce "analyzing rhythm-stand clear!" and allow AED to determine rhythm.
- e. If the AED determines that a shock is to be delivered, allow AED to charge while continuing CPR. Once the machine signals it is ready to defibrillate, announce "stand clear!" Verify that no one is in contact with the patient and press the shock button.
- f. Immediately resume CPR for 2 minutes. Re-analyze. Defibrillate if indicated.
- g. If "no shock advised", check carotid pulse for 5-10 seconds. If pulse present and no breathing, ventilate at 8-10 breaths per minute.
- h. ALS / LALS providers: if patient remains pulseless after the first two shocks, while CPR continues insert appropriate airway adjunct and ventilate 8-10 breaths per minute (if patient appears to be 4 feet or taller).
- i. If the machine prompts "check patient", analyze patient and continue with defibrillation and CPR in accordance with Policy #7200.

### II. Three Shock Programmed Device:

- a. After first shock may ignore prompts and deliver 2 min. of CPR, then analyze  
**Or**
- b. May follow manufacturer guideline of 3 stacked shock protocol. This may be necessary with automatic AEDs that analyze and delivers shock without user pushing button, or non-programmable AEDs.

### III. Transporting Responders and/ or ALS Rendezvous:

- a. After sixth shock is delivered, prepare patient for transport to basic emergency facility or rendezvous site.
- b. Once patient is in the rig, prior to leaving scene, you may reanalyze, if indicated by "check patient" prompt. Proceed as indicated by AED. If no shock advised, proceed with CPR and transport.
- c. While en route, if a "check patient" prompt is received, pull to the side of the road and analyze the rhythm. Proceed as indicated by AED. **This should be done only once during transport.**

### IV. Non-Transporting Responders:

- a. If patient persists in a shockable rhythm, continue administration of shocks, as per protocol until arrival of transport unit.

Medical Procedures

**Automated External Defibrillation (AED)**

**POLICY # 7210**

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- b. If patient presents with three (3) consecutive non-shockable rhythms, continue CPR and do not analyze unless AED prompts, "check patient". Minimize interruptions in CPR (e.g. to analyze rhythm, deliver shock). Keep interruptions as short as possible, 5-10 seconds if possible.

After six shocks, prepare for immediate transport, en-route rendezvous, or ALS/LALS

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

MEDICAL PROCEDURES

**COMBITUBE**

**POLICY #7300**

**INDICATIONS:**

- Cardiac arrest.
- Respiratory arrest:
  - Unconscious.
  - No gag reflex.
  - Apnea or respiratory rate < 6/minute.

[ Appears at least 4 feet tall (for SA size) 5 feet tall (for regular size)]

**EQUIPMENT:**

- Combitube, regular size (required), SA (small adult) size recommended.
- Right angle emesis deflector.
- 140 mL syringe.
- 20 mL syringe.
- Suction catheter.
- Toomey syringe.

**PREPARATION OF EQUIPMENT:**

- Assemble all equipment.
- Inflate cuffs on the Combitube to test for leaks.
- Attach emesis deflector.
- Lubricate distal tip of Combitube.

**PROCEDURE:**

- Ventilate the patient with 100% oxygen prior to Combitube insertion.
- Place the head in a neutral position.
- Grasp the lower jaw with the thumb and index finger and lift. Hold the Combitube in the other hand (with its curvature in the same direction as the natural curvature of the pharynx).
- Blindly insert the tube gently into the mouth and advance into the throat until the front teeth are between the two black rings on the tube.
- Do not force the tube. If the tube does not advance easily, redirect it or withdraw and reinsert.
- Inflate cuff #1 with 100 mL of air (85 mL for SA size).
- Inflate cuff #2 with 15 mL of air (12 mL for SA size).
- Ventilate via tube #1.
- Check for chest rise, auscultate the epigastric area for absence of abdominal sounds, and the lungs bilaterally for breath sounds.
- Attach Toomey to tube #2 and aspirate. If chest rise and bilateral breath sounds are present, no abdominal sounds noted, and there is resistance when aspirating with Toomey syringe, the tube is in the esophagus.
- Continue to ventilate through tube #1 and secure tube in place.
- If there is no chest rise, breath sounds, or abdominal sounds, and you are able to pull back freely on the Toomey syringe without resistance, the tube may be in the trachea.
- Ventilate via tube #2 and reassess for chest rise, breath sounds and abdominal sounds.
- If assessment confirms that tube is in trachea, continue to ventilate through tube #2 and secure tube in place.
- If unable to confirm tube placement, remove tube and ventilate with BVM attached to 100% oxygen.
- May reattempt Combitube placement twice, ventilating patient for 30 seconds between attempts.
- If unable to successfully place Combitube after three attempts, continue ventilations with BVM.

MEDICAL PROCEDURES

**COMBITUBE**

**POLICY #7300**

**PROBLEM SOLVING:**

- Air leaking from mouth/nose
  - Add 20mL air to cuff #1.
  - If still leaking add additional 20 mL of air to cuff #1.
  - If still leaking assume cuff leak and remove tube.
- Insertion too far into esophagus.
  - No chest rise or breath sounds, when ventilating via tube #1.
  - Unable to pull back on Toomey syringe.
  - Gurgling over abdomen , no chest rise, or breath sounds when ventilating via tube #2.
  - Deflate cuff #1, then cuff #2, pull back 3 cm, re-inflate cuff #1, then cuff #2.
- Possible asthma, COPD or drowning:
  - Poor chest rise while ventilating via tube #1.
  - Distant breath sounds.
  - Can't pull back on Toomey syringe.
  - No chest rise or breath sounds, gurgling over abdomen when ventilating via tube #2.
  - Toomey syringe and abdominal sounds may be most reliable assessments.
  - If no breath sounds or gurgling and can't aspirate with Toomey syringe—**Pull the tube.**
- Cardiac arrest:
  - May be able to continue CPR during attempts.
  - Maximum 30 seconds per attempt.
  - Only one attempt per one-minute cycle of CPR.
- Unusual circumstances:
  - Patient position (entrapment, arthritis of spine, patient cannot lie flat (supine).
  - Insertion may be attempted as long as ventilation & assessment can be completed.
- In rare situations, Toomey syringe can be relied upon solely.
  - Unilateral breath sounds with absent gastric sounds (unlikely to be right mainstemmed with Combitube):
    - Pneumothorax.
    - Hemothorax.
    - Pneumonectomy.
  - Leave Combitube in place and continue ventilation if Toomey syringe confirms location.
- Facial trauma:
  - If unable to visualize cords for ET insertion or unable to get mask seal with BVM, insert Combitube.
  - Suction prior to insertion.
  - Avoid broken teeth, bone fragments.
  - Maintain spinal stabilization.

**INDICATIONS FOR EXTUBATION:**

- Unable to confirm placement when ventilating via tube #1 or tube #2.
- Mechanical failure of tube.
- Patient actively resists tube.

**EXTUBATION PROCEDURE:**

- Consider decompressing stomach if tube in esophagus, using 12 fr catheter included in kit.
- Suction mouth if necessary.
- Deflate cuff #1 (100 cc)
- Deflate cuff #2 (15 cc)
- Turn patient on side.
- Remove tube with suction readily available.

MEDICAL PROCEDURES

**COMBITUBE**

**POLICY #7300**

**CONTRAINDICATIONS:**

- Obvious signs of death.
- Do-Not-Resuscitate.
- Gag reflex.
- Won't advance due to resistance.
- Known esophageal disease (cancer, varices, surgery).
- Known ingestion of caustic substance.
- Known narcotic OD (prior to Narcan administration).
- Laryngectomy patient with stoma.

**DOCUMENTATION:**

Documentation shall include:

- Presence of bilateral breath sounds.
- Verification that the esophageal detector device (Toomey syringe) indicated tracheal or esophageal placement.
- Which tube is being used to ventilate the patient, #1 or #2.
- Number of attempts required.
- Any procedural problems or complications.

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**APPROVAL**



**Bruce Haynes, M.D.**  
**EMS Medical Director**

MEDICAL PROCEDURES

**EXTERNAL JUGULAR VEIN CANNULATION**

**POLICY #7400**

**INDICATIONS:**

- To establish IV access in critical adult and pediatric patients when unable to establish peripheral IV access.

**EQUIPMENT:**

- Iodine or alcohol preparation.
- Large gauge (#16 or #18) intravenous cannula.
- IV fluid and tubing.
- Adhesive tape.

**PROCEDURE:**

- Place patient in supine position.
- Elevate shoulders on rolled towel or sheet and suspend head and neck in hands of assistant.
- Turn patient's head 45° to 60° to one side.
- Cleanse venipuncture site with iodine preparation.
- Stimulate the pediatric patient to cry to cause engorgement of the vessel.
- Tamponade the vein with forefinger just above the clavicle, midclavicular line.
- Stabilize skin over vein with thumb.
- Puncture skin midway between angle of the jaw and midclavicular line, at a shallow angle. Align the needle and syringe in the direction of the vein and advance cannula.
- Maintain compression on the vein continuously with forefinger until cannula is completely inserted, needle has been removed, and IV tubing is connected. This keeps a closed system and prevents the possibility of air entering the vein.
- Release tamponade over vein and adjust IV flow to desired rate.
- Secure IV site.

**NOTES:**

- **Maximum two attempts permitted using one side only.**
- **Monitor for air embolism, catheter embolism, hematomas, or infiltration.**
- **Remove IV cannula immediately if a hematoma or infiltration occur and apply direct pressure until bleeding stops (approximately 5 minutes).**

Approved:



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Bruce Haynes, M.D.  
EMS Medical Director

MEDICAL PROCEDURES

**NEEDLE THORACOSTOMY**

**POLICY #7500**

**INDICATIONS:**

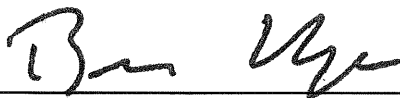
Rapidly deteriorating patient with severe respiratory distress who has signs and symptoms of life-threatening tension pneumothorax, such as:

- Progressively worsening dyspnea.
- Hypotension.
- Shock.
- Decreased or diminished breath sounds on the affected side.
- Distended neck veins.
- Tracheal deviation away from the affected side.

**PROCEDURE:**

- Base Hospital order required.
- Explain procedure to patient, place patient in upright position if tolerated.
- Assemble equipment:
  - 14 or 16 gauge 2 to 2½ inch needle and cannula with syringe attached. Use 20g, 1 inch needle and cannula for patients < 40 kg.
  - antiseptic wipes.
  - sterile 4 x 4's.
  - tape.
- Prepare area with antiseptic wipes at second intercostal space, midclavicular line.
- Insert needle perpendicular to the chest wall, at the level of the superior border of the third rib until needle is in contact with the rib. Maintain negative pressure on the syringe while inserting the needle.
- Maintain the needle in position, slowly 'walk' the needle with cannula over the **superior border** of the rib and advance until the pleural space is entered evidenced by one or more of the following:
  - a "popping" sound or "giving way" sensation
  - a sudden rush of air
  - ability to aspirate free air into the syringe
- Remove needle; leave cannula in place.  
**CAUTION:** Do not reinsert needle into cannula due to danger of shearing cannula.
- Evaluate the effectiveness of the procedure by:
  - immediate, obvious improvement in respiratory status, signs and symptoms, vital signs, and lung sounds.
- Secure the cannula with dressing and tape allowing cannula to remain in patient.
- If there is no improvement, this procedure may be repeated.

**APPROVAL:**



**Bruce Haynes, M.D.**  
**EMS Medical Director**

I. Purpose: To define training requirements for Emergency Medical Technician-Paramedics (EMT-P) and utilization of Pre-Existing Vascular Access Devices (PVADs) in the prehospital setting.

II. Policy: Paramedics shall successfully complete the PVAD training module at an Imperial County EMS Training Institute or Base Hospital prior to administering fluids and/or medications through a PVAD in the field setting.

III. Definition: A pre-existing vascular access device is an indwelling catheter/device placed into one of the central veins to provide vascular access for those patients requiring long term intravenous therapy or Hemodialysis.

IV. Content:

A. Types of Catheters

1. External indwelling catheters/devices

a. **Heparin/Saline Lock** - A temporary venous catheter placed in a peripheral vein and occluded with a cap. Heparin or saline is instilled prior to capping the catheter to maintain its patency. It may be accessed directly through the injection cap.

b. "**BROVIAC@** catheter", "**HICKMAN@** catheter", "**GROSHONG@** catheter", and others - a long catheter that is inserted into the right atrium, through a central vein. The catheter enters the skin through an incision in the chest. The line may be heparinized and may be accessed directly through the injection cap. These catheters are usually multi-lumened and any lumen can be used. If the catheter is color coded, the red lumen is usually the largest.

c. **Peripherally inserted central catheter (PICC)** - a long catheter inserted antecubitally into the subclavian vein or superior vena cava. It may be accessed through the injection cap.

2. Internal, indwelling devices

a. **Internal Subcutaneous Infusion Ports** - an access device embedded subcutaneously and must be accessed through the skin. **THIS DEVICE IS NOT TO BE USED BY PREHOSPITAL FIELD PERSONNEL.**

b. **Internal Hemodialysis Fistula** - A permanent access device that diverts blood flow from an artery to a vein and is usually located in the forearm or femoral area. It is used for dialysis.

B. Indications

1. Heparin/Saline Lock - any situation requiring access for IV fluids or medications.

2. External Indwelling Catheters - Urgent need to administer fluids and/or medications, which can only be given by the IV route, and a peripheral IV site is not readily available.

3. Hemodialysis Fistula - Urgent need to administer fluids and/or medications, which can only be given by the IV route and an alternate IV site is not readily available.

C. Fluids/Medications approved for infusion through PVAD.

1. IV fluids: Normal Saline
2. Medications: All EMT -P scope of practice medications recommended for venous administration.

D. Complications

1. Infection. Due to the location of the catheter end, strict adherence to aseptic technique is crucial when handling these devices. The injection cap must be cleansed thoroughly with an alcohol wipe. Sterile gloves are not necessary. Care must be used not to contaminate the needle used to access the line or the IV tubing used.
2. Air embolism. The devices provide a direct line into the circulation; therefore the introduction of air into the device is possible. Do not remove the injection cap from the catheter. Do not allow IV fluids to run dry. Clear all air from the IV tubing and syringes prior to administration of fluids or medications.
3. Thrombosis. Improper handling and maintenance of the device may dislodge a clot causing pulmonary embolus or vascular damage. Check patency of the line by slowly injecting 5 cc of NS (see Step 7 below). *Do not* inject medications or infuse fluids if resistance is met when establishing patency of the catheter. Flush line with 5 ml of normal saline after medication administration.
4. Catheter damage. These catheters are meant for long-term use. They usually require a surgical procedure and are costly to insert. Care must be taken to avoid any damage to the catheter. If damage to the catheter occurs, immediately clamp the catheter between the skin exit site and the damaged area to prevent air embolism or blood loss. Always use a 10 ml or larger syringe to prevent catheter damage from excess pressure when injecting directly. Use caution when inserting the needle into the injection port.

E. Procedure

1. Assemble necessary equipment – two (2) 10 cc syringes, NS for injection, IV tubing and fluid, alcohol wipes, 18 gauge needles or needleless system.
2. Disconnect any existing IV lines.
3. Prepare a 10 cc syringe with NS and set up IV line.
4. Prep injection cap with alcohol wipe.
5. Clamp catheter if unclamped.
6. Withdraw 5 cc's and discard syringe. If resistance is met, discontinue procedure.
7. Slowly inject 5 cc, if resistance is met, discontinue procedure.
8. Prep injection cap with alcohol wipe.

MEDICAL PROCEDURES

**PRE-EXISTING VASCULAR ACCESS DEVICES (PVADs)**

**POLICY #7600**

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9. Attach 18-gauge needle or needless cap to IV tubing and insert into injection cap.
10. Regulate IV rate.
11. Tape needle to catheter to prevent dislodging.
12. Administer medications through IV line.
13. Flush line with IV fluid after medication administration.
14. Closely monitor IV line and Catheter.

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**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

I) PURPOSE:

The Perilaryngeal Airway Device (King LTD) is a single use piece of equipment intended for airway management. It can be used as a rescue airway when other airway management techniques have failed or as a primary device when advanced airway management is required in order to provide adequate ventilation. The Perilaryngeal airway does not require direct visualization of the airway or significant manipulation of the neck.

Its main use is in cardiac arrest situations (pulseless and apneic patients). In some patients it may be preferable to use initially (e.g. patients who are obese or with short necks, patients with limited neck mobility, difficult visualization due to access to the patient, or blood or emesis in the airway, during cardiac arrest to avoid interruption). It is not necessary to attempt endotracheal intubation before initiating the use of the perilaryngeal airway.

Because it is not tolerated well in patients with airway reflexes, it should not be used in responsive patients unless all other methods of ventilation have failed.

Two intubation attempts with the perilaryngeal airway are permissible. Ventilations should be interrupted no more than 30 seconds per attempt. Between attempts, patients should be ventilated with 100% oxygen for one minute via bag-valve mask device.

The King Airway is available in three sizes and cuff inflation varies by model:

- A. Size 3 (yellow cap) – Patient between 4 and 5 feet tall (40 - 55 ml air)
- B. Size 4 (red cap) – Patient between 5 and 6 feet tall (50 - 70 ml air)
- C. Size 5 (purple cap) – Patient over 6 feet tall (60 - 80 ml air)

II) INDICATIONS:

- A. Cardiac arrest (of any cause)
- B. Inability to ventilate non-arrest patient (with BLS airway maneuvers) in a setting in which endotracheal intubation is not successful or unable to be done.

III) CONTRAINDICATIONS:

- A) Presence of gag reflex
- B) Caustic ingestion
- C) Known esophageal disease (e.g. cancer, varices, stricture, others)
- D) Laryngectomy with stoma
- E) Height less than 4 feet

Note: Airway deformity due to prior surgery or trauma may limit the ability to adequately ventilate with this device (may not get adequate seal from pharyngeal cuff)

MEDICAL PROCEDURES

**Rescue Airway - Perilaryngeal Airway (King LTD)**

**POLICY# 7700**

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IV) EQUIPMENT:

- A) Suction
- B) King Kit (size 3,4, or 5)
- C) Bag-Valve Mask
- D) Stethoscope
- E) End-tidal CO<sub>2</sub> detection device

V) PROCEDURE:

- A) Assure an adequate BLS airway (if possible).
- B) Select appropriately sized perilaryngeal airway.
- C) Test cuff inflation by injecting recommended amount of air for tube size into the cuffs. Remove all air from cuffs prior to insertion
- D) Apply water-based lubricant to the beveled distal tip and posterior aspect of tube, taking care to avoid introduction of lubricant in or near ventilation openings.
- E) Have a spare perilaryngeal airway available for immediate use.
- F) Oxygenate with 100% oxygen.
- G) Position the head. The ideal head position for insertion is the “sniffing position”. A neutral position can also be used (e.g. spinal injury concerns).
- H) Hold mouth open and apply chin lift unless contraindicated by cervical spine injury or patient position.
- I) With tube rotated laterally 45-90 degrees such that the blue orientation stripe is touching the corner of the mouth, introduce tip into mouth and advance behind base of tongue. **Never force the tube into position.**
- J) As the tube tip passes under tongue, rotate tube back to midline (blue orientation stripe faces chin).
- K) Without exerting excessive force, advance tube until base of connector aligns with teeth or gums.
- L) Inflate cuff to required volume
- M) Attached bag-valve to airway. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing.
- N) Confirm proper position by auscultation, chest movement, and verification of CO<sub>2</sub> by Capnography. Do not use esophageal detector device (EDD) with perilaryngeal airway.
- O) Secure the tube. Note depth marking on tube.
- P) Continue to monitor patient for proper tube placement throughout prehospital treatment and transport. **Capnography should be done in all cases.**
- Q) Document airway placement and results of monitoring throughout treatment and transport.

Troubleshooting:

- R) If placement is unsuccessful, remove tube, ventilate with BVM and repeat sequence of steps.
- S) If unsuccessful on second attempt, BLS airway management should be resumed.

MEDICAL PROCEDURES

**Rescue Airway - Perilaryngeal Airway (King LTD)**

**POLICY# 7700**

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**APPROVAL**



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Bruce E. Haynes, M.D.  
EMS Medical Director

MEDICAL PROCEDURES

**INTRAOSSEOUS INFUSION (PEDIATRIC and ADULT)**

**POLICY # 7800**

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I. PURPOSE

Intraosseous cannulation provides a safe and reliable method for rapidly achieving a route for administration of medications, fluids, and blood products in a non-collapsible vascular space.

II. INDICATIONS

- A. One failed attempt at intravenous access or after evaluation of potential IV sites, it is determined that an IV attempt would not be successful and patient meets one of the following criteria;
  - 1. One of the following conditions exists:
    - 1. Cardiac or respiratory arrest, impending arrest, or unstable dysrhythmia
    - 2. Shock or evolving shock, regardless of cause.

III. ABSOLUTE CONTRAINDICATIONS

- A. Fracture or suspected vascular compromise of the selected tibia.
- B. Congenital deformity or history of osteogenesis imperfecta or osteoporosis
- C. Previous IO attempt at the chosen site
- D. Inability to locate anatomical landmarks for insertion.
- E. Patient <3kg

IV. RELATIVE CONTRAINDICATIONS

- A. Skin infection or burn overlying the area of insertion.

V. EQUIPMENT

- A. Povidone-based solution
  - B. IV of NS attached to 250 mL bag in pediatric patients
  - C. IV of NS attached to 1000 mL bag in adult patients
  - D. 10/12 mL syringe filled with normal saline
  - E. Sterile gloves
  - F. Adhesive tape
  - G. EZ Stabilizer
  - H. Pressure bag for IV fluid administration
  - I. Intraosseous needle (suitable up to age 8)
- OR/AND-**
- J. Automated IO insertion device (EZ-IOPD) up to 40 kg
  - K. Automated IO insertion device (EZ-IOAD) if over 40 kg
  - L. Lidocaine 2% for injection

VI. PROCEDURE

- A. Locate and prepare the insertion site. For children, place supine with a rolled towel under the knee, restrain if necessary. Select extremity (if applicable) without evidence of trauma or infection.
- B. Put on gloves and thoroughly prepare the area with the antiseptic solution.

MEDICAL PROCEDURES

**INTRAOSSEOUS INFUSION (PEDIATRIC and ADULT)**

**POLICY # 7800**

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- C. Locate insertion site:
  - i. In small children (3-12 kg), the tibial tuberosity cannot be palpated as a landmark, so the insertion site is two finger-breadths below the patella in the flat aspect of the medial tibia.
  - ii. In larger children (13-39 kg), the insertion site is located on the flat aspect of the medial tibia one finger breadth below the level of the tibial tuberosity. If tibial tuberosity not palpable, insert two finger-breadths below the patella in the flat aspect of the medial tibia.
  - iii. For adults, proximal or distal tibial sites may be utilized.
    - 1. The proximal tibial site is one finger-breadth medial to the tibial tuberosity.
    - 2. The distal tibial site is 2 finger-breadths above the medial malleolus (inside aspect of ankle) in the midline of the shaft of the tibia.
- D. Stabilize extremity.
- E. Introduce the intraosseous needle at a 90 degree angle, to the flat surface of the tibia.
- F. For manual insertion, pierce the bony cortex using a firm rotary or drilling motion (do not move needle side to side or up and down). A distinct change in resistance will be felt upon entry into the medullary space.
- G. Remove the stylet and confirm intramedullary placement by injecting, without marked resistance, 10 mL normal saline.
- H. Attach IV tubing to the intraosseous hub.
- I. Anchor needle to overlying skin with tape or EZ Stabilizer.
- J. If unable to establish on first attempt, make on attempt on opposite leg, no more than two (2) attempts total.
- K. Monitor pulses distal to area of placement
- L. Monitor leg for signs of swelling or cool temperature which may indicate infiltration of fluids into surrounding tissues.
- M. For adult patients who awaken and have pain related to infusion, slowly administer **SO - LIDOCAINE** 40 mg IO. May repeat dose once at 20 mg LIDOCAINE IO.
- N. For pediatric patients with pain related to infusion, slowly administer **SO - LIDOCAINE** 0.5 mg/kg IO (max dose 20 mg).

VII. POSSIBLE COMPLICATIONS

- A. Local infiltration of fluids/drugs into the subcutaneous tissue due to improper needle placement.
- B. Cessation of the infusion due to clotting in the needle, or the bevel of the needle being lodged against the posterior cortex.
- C. Osteomyelitis or sepsis
- D. Fluid overload
- E. Fat or bone emboli
- F. Fracture

**APPROVAL**



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Bruce E. Haynes, M.D.  
EMS Medical Director

I) PURPOSE:

- A. The purpose of this policy is to define the indication and procedures required for the use of Continuous Positive Airway Pressure (CPAP) by paramedics.

II) INDICATIONS:

- A. The purpose of CPAP is to improve ventilation and oxygenation in an effort to avoid intubation in patients who present with congestive heart failure (CHF) with acute pulmonary edema or other causes of severe respiratory distress.
- B. CPAP is authorized for use in patients who are 14 years of age and older with any one of the following:
- 1) Awake, alert and able to follow commands.
  - 2) Able to maintain a patent airway.
  - 3) Exhibit two or more of the following:
    - (a) Respiratory rate > 24
    - (b) Pulse Oximetry < 94%
    - (c) Use of accessory muscles during respiration
- C. Conditions in which CPAP may be helpful include suspected:
- 1) Congestive Heart Failure (CHF) with acute pulmonary edema.
  - 2) Acute exacerbation of COPD or asthma.
  - 3) Near drowning/submersion
  - 4) Other causes of severe respiratory distress, excluding trauma

III) CONTRAINDICATIONS:

A) Absolute Contraindications (Do Not Use):

- 1) Respiratory or cardiac arrest
- 2) Agonal/failing respirations
- 3) Inability to maintain airway
- 4) Altered Mental Status - can't cooperate
- 5) Systolic blood pressure <90mmHg
- 6) Signs and symptoms of pneumothorax
- 7) Major facial, head or chest trauma
- 8) Facial abnormalities or inability to obtain a mask seal
- 9) Tracheostomy
- 10) Unconsciousness
- 11) Vomiting

MEDICAL PROCEDURES

**CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)**

**POLICY# 7900**

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- B) Relative Contraindications (Use Cautiously):
    - 1) Claustrophobia or unable to tolerate mask
  - IV) EQUIPMENT:
    - A) CPAP pressure generator and circuit set with ability to deliver 5.0 cm to 10 cm of H<sub>2</sub>O pressure
    - B) Appropriate sized face mask and straps
    - C) Inline nebulizer if required for bronchodilator administration
    - D) Sufficient oxygen supply
  - V) PROCEDURE:
    - A) Place patient in a seated position.
    - B) Monitor ECG, Vital Signs (BP, HR, RR, SpO<sub>2</sub>)
    - C) Monitor vital signs every five (5) minutes; SpO<sub>2</sub> must be used continuously to monitor patients oxygen saturation
    - D) Set up the CPAP system (per manufacturers recommendation) with pressure set at 5-10 cm H<sub>2</sub>O (Pulmonary® O2-RESQ™, Boussignac and WhisperFlow)
    - E) Explain to the patient what you will be doing
    - F) Verify that oxygen is flowing to the mask. Apply mask while reassuring patient – encourage patient to breathe normally (may have a tendency to become anxious or panic – reassure and coach)
    - G) Do not exceed 10 cm of H<sub>2</sub>O pressure
    - H) Reevaluate the patient – normally the patient will improve in the first 5 minutes with CPAP as evidenced by:
      - 1) Decreased heart rate
      - 2) Decreased respiratory rate
      - 3) Decreased blood pressure
      - 4) Increased SpO<sub>2</sub>
    - I) If the patient does not improve or becomes worse with CPAP, remove the CPAP device and assist ventilations with BVM as needed
    - J) Notify the receiving facility of the type of CPAP device that is being used
- 

**APPROVAL**



Bruce E. Haynes, M.D.  
EMS Medical Director

TRAUMA SYSTEM

**Injury Prevention Programs**

**POLICY #8100**

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- I. Authority Health and Safety code, Division 2.5, Sections 1797.107 and 1798.161
  
- II. Purpose To establish guidelines for the coordination of Injury Prevention Programs between trauma centers and public and private agencies
  
- III. Policy
  - A. Trauma Centers as a part of their contractual agreement as a designated trauma center will participate in injury prevention programs with public and private agencies. These could include such established programs as, DARE, ENCARE, or Safe Kids.
  
  - B. Trauma Centers may produce their own Injury Prevention Programs based upon data analysis of the trauma system review at their facility. These might address community issues such as bicycle helmet safety, playground safety, or issue-specific programs defined by the higher volume injuries in the database.
  
  - C. Trauma Centers may utilize information developed by the EMS Agency as a result of system review to produce injury prevention programs for the public and private sector in their communities.
  
  - D. The EMS Agency is involved in injury prevention through a collaborative effort with the trauma centers. The EMS Agency will provide data reflective of the types of injuries throughout the entire county. Annual reporting from the trauma registry will provide the basis for the development of injury prevention programs.

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APPROVAL



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EMS Medical Director



Ryan Kelley  
EMS Manager

Authority Health and Safety code, Division 2.5, Sections 1798.163 and 1798.165

II. Purpose To provide a guideline for utilization of the trauma terminology in marketing and advertising by a trauma care provider within the Imperial County EMS and Trauma System

III. Policy

A. In accordance with Section 1798.165 of the Health and Safety Code, " No health care provider shall use the terms, trauma facility, trauma hospital, trauma center, trauma care provider, trauma vehicle or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the local EMS Agency.

B. Prior to implementation any marketing or advertising material will be reviewed by the EMS Agency based upon the following guidelines:

- 1) Shall provide accurate information
- 2) Shall not include false claims
- 3) Shall not be critical of other providers
- 4) Shall not include financial inducements to any providers or third parties.

C. Any local consumer protection ordinances related to advertising and marketing must be adhered to.

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APPROVAL

  
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EMS Medical Director

  
John Pritting  
EMS Manager

TRAUMA SYSTEM

**Repatriation of Stable Trauma Patient**

**POLICY #8300**

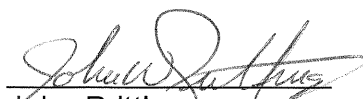
- I. Authority Health and Safety code, Division 2.5, Sections 1798.163 and 172
- II. Purpose To establish guidelines for repatriation of stable trauma patients to their health plan's facility.
- III. Policy
- A. All stable trauma patients shall be transferred to their health provider's facility when requested, as long as such transfer is medically prudent and in the best interest of the patient. All requests/discussions concerning transfer status of the patients will be made physician to physician. Transfer agreement will be based on patient condition and appropriateness of receiving facility resources.
- B. Unless otherwise decided by the trauma surgeon or ED physician of record, no trauma patient requiring acute care admission will be transferred to a hospital that is not a designated trauma center until the condition is stable enough to be adequately cared for at that facility.
- C. Hospitals which have repatriated trauma patients from designated trauma centers shall:
- i. Provide the information required to complete the trauma registry on that patient to the transferring trauma center, and,
  - ii. Participate when indicated in system and trauma center quality improvement activities for those patients who have been transferred.
- D. Trauma patients seen at Imperial County trauma centers may require diagnostic evaluation or immediate treatment prior to transfer. Trauma center evaluation does not necessitate preapproval by the patient's insurer.

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APPROVAL



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John Pritting  
EMS Manager

TRAUMA SYSTEM

**Trauma Catchment Service Areas**

**POLICY #8400**

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- I. Authority: Health and Safety Code, Division 2.5, Section 1798.165
- II. Purpose: To designate catchment service areas for each designated trauma center.

III Definition:

Trauma Catchment Area – Geographic Area with defined boundaries assigned to a designated trauma center for purposes of care for patients identified as critical trauma patients.

IV Policy:

- A. The patient who is identified as a critical trauma patient will be transported to the closest most appropriate trauma center, that is within a thirty-minute transport from the scene.
- B. Ground transport units have defined catchment areas of transport that will support the thirty-minute zone. The catchment areas are defined by narrative description (page 22) and map (Appendix A) for each of the designated trauma centers.
- C. When transport to the closest most appropriate trauma center is beyond the thirty-minute zone for that trauma center's catchment area, then air transportation should be considered. It is necessary to provide the Imperial County Sheriff's dispatch center with this information to activate the dispatch of an air ambulance.
- D. Utilization of air transportation will extend the boundaries of the catchment areas and facilitate transport.

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APPROVAL



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TRAUMA SYSTEM

**Trauma System Quality Improvement**

**POLICY #8500**

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- I. Authority:
  - a. Health and Safety Code, Division 2.5
  - b. California Code of Regulation, Title 22, Division 9
  
- II. Purpose  
To monitor and evaluate the medical care of patients with traumatic injuries
  
- III Policy

Structure

The Trauma System quality improvement process will be provided by two major components: the internal program within each trauma center, and the system process which includes; the scheduled Trauma Audit Committee (TAC) meetings, ongoing periodic review of each trauma center by the Emergency Medical Services Agency and the periodic evaluation of trauma care and the trauma system by an outside review team.

Process

TAC is an advisory committee to Imperial County Emergency Medical Services on issues related to trauma care. TAC will function as a sub-committee of the Emergency Medical Care Committee.

Trauma System Monitoring Role

- 1. The Committee will assist the EMS Agency in the review and evaluation of the medical aspects of the trauma system.
- 2. The Committee shall meet to monitor and assess the effectiveness of the trauma system and make known its findings and recommendations to the EMS Agency.

Scope of Audit Review

The scope of the review to be conducted by the committee will include, but not be limited to a review of the following:

- a) Trauma Deaths
- b) Appropriateness of triage criteria
- c) Prehospital trauma care
- d) Appropriateness of the level of trauma team activation
- e) Timely availability of trauma team members
- f) Hospital trauma care
- g) Appropriateness of by-pass and transfers
- h) Patient outcomes

### Membership

The membership shall be broad based and shall represent the participants in the Trauma Care System and the local medical community. All positions are for a two-year term and may be renewed at the pleasure of the EMS Agency Medical Director.

### Members:

- a) ED Physician representative from each trauma center
- b) Trauma Nurse representative from each trauma center
- c) Surgeon representative as needed
- d) Surgical sub-specialist as needed
- e) Prehospital provider representatives, one private Ambulance, one fire department and representatives from air ambulance providers
- f) EMS Dispatch representative, as needed
- g) EMS Agency representative(s)
- h) Medical Examiner/Coroner representative as needed
- i) Other members as deemed appropriate

### Attendance

1. Members are expected to participate in at least 50% of scheduled meetings
2. At a minimum the committee will meet quarterly
3. The EMS Agency Medical Director makes appointment to the committee.
4. Resignation from the committee should be in writing to the EMS Agency
5. Invitees may participate in the medical review of specific cases when their expertise is requested.

### Minutes

Due to the confidential nature of the committee business, minutes shall be distributed at the beginning of each meeting and collected at the close of each meeting by EMS staff. No copies may be made or possessed by members of the Committee outside of the meeting.

### Confidentiality

1. All proceedings, documents and discussions of the Trauma Audit Committee are confidential and are covered under Section 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of

TRAUMA SYSTEM

**Trauma System Quality Improvement**

**POLICY #8500**

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testimony is provided to the Committee, which is established by a local government agency to monitor, evaluate, and report on the necessity, quality and level of specialty health services, including but not limited to, trauma care services.

2. Issues requiring system input may be sent in total to the EMS agency for input. Guests may be invited to discuss specific cases and issues in order to assist the Committee in making final case or issue determination. Guests may only be present for the portions of the meeting they have been requested to review or testify about.
3. All members must sign a confidentiality agreement not to divulge or discuss information that has been obtained solely through medical audit committee membership. Prior to any guest participation in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement from the invited guest.

Trauma Audit Process

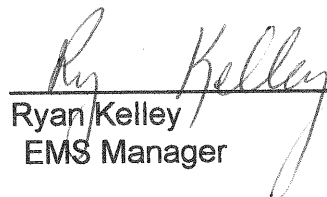
The committee, to guide them in case review, will establish audit screens. In every case review, the committee will make a finding of the appropriateness of the care rendered and will make recommendations regarding changes in the system to ensure appropriate care.

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APPROVAL



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EMS Medical Director



Ryan Kelley  
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## INTERFACILITY TRANSFER GUIDELINES

**Policy:** Patients with a level of acuity or need for diagnostics/treatment or consultation not available at any Imperial County hospital, will be transferred appropriately, expediently, and in compliance with EMTALA regulations. Relationships between receiving and transferring hospitals will allow for collegial education and feedback about transferred patients and the transfer process.

**Procedure:**

**I. Identify Patients:**

Any patient who may require resources, exceeding the trauma services available at the closest facility.

A. When patients present to the Emergency Department, begin initial evaluation and stabilization. The Emergency Department physician makes the determination of need for transfer. There should be simultaneous effort made to arrange for transfer while stabilizing care is delivered.

**II. Provide Necessary Interventions:**

This may include securing an airway, establishing venous access, performing procedures (such as chest tube insertion) administering medications, etc. There is no requirement for the transferring facility to stabilize the emergency medical condition necessitating transfer. Some conditions may not be able to be stabilized prior to transfer. Delays in transfer to obtain diagnostics or await test results should be avoided in high acuity patients. However, every attempt should be made to minimize the potential risks of transfer. If stabilizing operative procedures must be done prior to transfer, arrangements for transfer and acceptance at the higher-level trauma center should be initiated simultaneously. The patient remains an ED patient of record during the operative procedure and is transferred as soon as possible after the operative phase of care.

**III. Contact the Receiving Trauma Center.**

Secure a receiving facility and select the appropriate mode of transportation and level of care required in route. If pediatric patients meet the pediatric trauma triage criteria, transfer to Children's Hospital- San Diego is the appropriate destination for children ages 14 and under. Contact the appropriate receiving

service, (Attachment A) at the desired receiving facility. Higher-level trauma centers are expected to accept patients from facilities that lack the resource to provide the required care, if they have the necessary resources. They may require physician acceptance at their facility prior to transfer. Follow the requirements of the receiving facility regarding physician-to-physician contact and acceptance.

**IV. Obtain Consent**

Obtain informed patient consent for transfer. If the patient is unable to provide consent, obtain consent from family if possible. If the patient is unable to provide consent, and family is not available, the patient may be transferred under implied consent.

**V. Have Transfer Documents Ready**

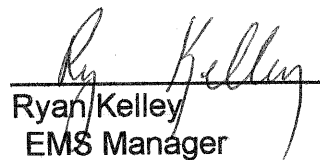
Send the available information to the receiving facility. Information may be sent directly with the patient, or be sent by fax after the patient has departed. Include information such as demographics, procedures done; plan ahead and have appropriate copies ready for the transport unit when they arrive. Do not delay transfer due to preparation of transfer documents

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**APPROVAL**



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EMS Medical Director



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ATTACHMENT A  
RECEIVING FACILITIES

Note: To serve as a template only – each facility should individualize as needed. An adequate number of options in each category must be provided to accommodate transfers when staffed beds are not available at earlier choices. All listed facilities can accept ground or air transports, method selected will be driven by patient need.

Major Trauma Patients

**UCSD – SAN DIEGO**

HOSPITAL CONTACT: Call the In-house Trauma Attending

PHONE: **619-543-6737** Page operator and ask for

The Trauma Attending on-call

or Call The Trauma Unit direct line and ask the Resuscitation  
Nurse to page the trauma attending on call.

PHONE: **619-543-6745**

or Call The trauma service office during business hours  
There is an answering service during off hours

PHONE: **619-543-7200**

**SCRIPPS MEMORIAL HOSPITAL – SAN DIEGO**

HOSPITAL CONTACT: Transfer Center

PHONE: **858- 626-6140** (0630 –1900 Mon-Fri)

Nighttime: **858-626-6157** Saturday/Sunday after 2100

Call the ED for all other times 858-626-6151

**DESERT HOSPITAL– PALM SPRINGS**

HOSPITAL CONTACT: For Field Transfers – Call their ED

PHONE: **760-323-6251**

HOSPITAL CONTACT: For ED transfers – Call the Trauma Service

PHONE : **1-800-24 SHOCK** (800-247-4625)

**CHILDREN'S HOSPITAL & HEALTH CENTER– SAN DIEGO**

HOSPITAL CONTACT: **CHET TEAM** for All Transports.

They will decide if ground or air transport is needed, and  
make arrangements for transport.

PHONE: **858-277-3404**

**Subject:** Trauma Transport Destination Guideline/Policy

**Authority:** Title 22, Division 9, Chapter 7

**Purpose:** To ensure that trauma patient destination is based upon the patient needs and the utilization of the highest level of resource available to provide timely appropriate trauma care.

Trauma Triage Criteria:

The primary goals of trauma triage in Imperial County is to rapidly and accurately identify victims who are at risk for life-threatening injuries. The specific criteria are identified in the guideline for, "Trauma Triage Criteria." Once a patient is identified as meeting the criteria to be classified as a trauma patient, the following guidelines are to be utilized in determining the appropriate patient destination.

Patient Destination Decision:

Patients who meet critical trauma triage criteria should be transported directly to the highest- level trauma center

- 1) Patients will be taken to the closest Level IV trauma center in Imperial County, unless they are critically injured and air transport is available.
- 2) When air transport is on scene then consideration of transport to a higher- level trauma center outside of the county is appropriate
- 3) If ground ambulance is on scene and air transport is in route to the scene, it may be in the patient's best interest to wait for air transport. Factors to consider include the severity of injury, air arrival time, and ground transport time to the Level IV trauma center. The Base Hospital should be consulted in making the determination to wait on scene for air transport.
- 4) Patients transported by ground ambulance that rendezvous with air transport at an alternate site, will have medical control provided by the air medical unit's base of operation, once the patient is turned over to the air transport team
- 5) Patients transported by ground ambulance that rendezvous with air transport at the Level IV trauma center helipad, are not required to have a medical clearance provided by the ED physician prior to air transport to a

higher- level trauma center. Medical control is maintained by the ground ambulance base hospital until the patient is turned over to the ALS air transport team. The use of the hospital helipad, (ground or roof), is looked upon as a 9-1-1 response location and does not obligate the hospital to provide a medical screening exam. If the ambulance provider (air or ground) request any medical intervention by hospital staff, the patients then becomes an ED patient and falls under the requirements for a medical screening exam.

Patient Destination Exceptions:

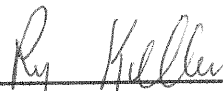
1. A trauma patient may at the option of the Base Hospital Physician, or air transport team, be brought to the closest appropriate medical facility, when the patient has life threatening condition, which overrides the need for expedient surgery. This would include conditions such as obstructed airway, tension pneumothorax, etc., which cannot be relieved or stabilized in the field.
2. Diversion – When a trauma center is on diversion and not able to respond to trauma activation (i.e. lack of CT, or lack of surgical coverage), notifications will be made according to the Hospital Diversion policy.

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APPROVAL



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EMS Medical Director



Ryan Kelley  
EMS Manager

**Critical Trauma Patient Criteria**

If any of the following apply, take to the highest level trauma center available, as per Trauma Patient Destination

**Physiologic:**

- Glasgow Coma Scale – Adults  $\leq 11$ , Children  $\leq 10$
- Systolic Blood Pressure < 90 mm Hg, 80 age 7-14, 70 age < 7
- Respiratory Rate < 10 or > 29

**Anatomic:**

- Penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Amputation proximal to wrist or ankle
- Spinal Injury with limb paralysis
- Flail chest
- Two or more obvious proximal fractures of femur or humerus

**Non Critical Trauma Patient**

Paramedic judgment should always be considered in identifying the traumatically injured patient. Utilize Base Medical direction whenever necessary.

If any of the following mechanisms or co-morbid factors exist consider transport to the nearest available trauma center or hospital if no trauma center within 30 minutes.

**Mechanism of Injury**

- Fall > 20 feet
- Pedestrian hit at 20 mph or thrown 15 ft.
- Death of same car occupant
- Unrestrained roll over
- Heavy extrication time > 20 minutes
- MC, ATV, Bicycle Crash
- Passenger compartment intrusion
- Patient ejected from enclosed vehicle

**Co-morbid Factors**

- Age < 5 or > 60
- Medical Illness: Cardiac or Respiratory Disease, Morbid obesity  
Diabetic, cirrhosis, immunosuppressed, anticoagulants
- Hostile environment (heat or cold)
- Pregnancy
- Presence of intoxicants

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APPROVAL



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EMS Medical Director



John Pritting  
EMS Manager

- I. Authority: Health and Safety Code, Division 2, Sections 1798.161 and 1798.163 and California Evidence code 1157.7
- II. Purpose: to establish a mechanism by which trauma registry information is obtained, stored, and utilized as part of the system assessment and quality assurance process.
- III. Policy: Each designated trauma center shall submit a trauma registry record for each patient who meets the definition of the Critical Trauma Patient as described in the trauma triage criteria which considers physiologic and anatomical findings. Patients who are triaged as Non-Critical Trauma Patients but are admitted or transferred to a higher-level trauma center shall be entered into the trauma registry. All trauma deaths that occur at the trauma center must be included in the trauma registry.
  - A. Submission:
    1. All trauma centers will submit their data electronically or by disc on a quarterly basis to the EMS Agency, on a schedule established by the TAC Committee.
    2. If a trauma registry record is updated at the trauma center, the revised record will be submitted to the EMS Agency.
  - B. Storage/Access:
    1. The Imperial County Trauma Registry will be stored in a secure manner with access restricted to personnel operating within the trauma quality assurance program.
    2. The Imperial County Trauma Registry will be utilized for quality assurance purposes and therefore will be protected from disclosure per the California Evidence code, Section 1157.7.
    3. The Imperial County Trauma Registry used strictly as a trauma database for the purpose of quality assurance is not subject to the mandated patient authorization procedures of HIPPA.
    4. Each Employee with access to the Imperial County Trauma Registry will sign an Imperial County Oath of Confidentiality and Trauma Audit Committee Confidentiality Agreement.
  - C. Utilization:
    1. The information within the trauma registry will be utilized primarily for quality assurance purposes related to the trauma system to monitor, evaluate and report on the necessity, quality and level of care provided by each hospital.

2. Aggregate data (does not include any patient or facility identifiers), may be utilized for reports, public health surveillance and injury prevention efforts in accordance with the TAC Committee expectations.
3. Specific information (without patient and facility identifiers) shall be integrated into the State EMS Authority data management system as required.

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APPROVAL



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John Pritting  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: ABDOMINAL DISCOMFORT (NON-TRAUMATIC)

POLICY NUMBER: 9100

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Ensure patent airway, give oxygen and/or ventilate prn Monitor O2 saturation prn Nothing by mouth Anticipate vomiting</p>	<p>Monitor ECG for upper abdominal pain in patients for whom a cardiac cause is a consideration (e.g., males &gt; 35 yrs; females &gt; 45 yrs/postmenopausal), Monitor O2 saturation prn</p> <p><b>SO</b> Establish Saline lock/IV prn <b>SO</b> Ondansetron 4mg ODT/IV/IM. <b>BH</b> Morphine Sulfate 2-10mg in 2mg increments IVP q 5 min. for pain if stable (Use caution: suspected intra-abdominal catastrophe - see note)</p> <p><b>If patient presents with a suspected intra-abdominal catastrophe:</b> <b>SO</b> 500 ml Normal Saline bolus IV; titrate fluid infusion to a systolic BP ≥ 90.</p> <p><b><u>PEDIATRIC NOTE:</u></b> <b>Refer to Pediatric Drug Guide</b> <b>BHP</b> Morphine Sulfate <b>BHP</b> Ondansetron 0.1mg/kg max of 4mg IV/IM For patients ≥ 40 kg; Administer one (1) Ondansetron 4mg ODT</p>
<p><b>NOTE:</b> Immediate transport for suspected intra-abdominal catastrophe (e.g., suspected ectopic pregnancy, abruptio placenta, abdominal aortic aneurysm, or unstable vital signs). Titrate fluid infusion to a systolic BP 90.</p>	

APPROVAL:



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Bruce E. Haynes, M.D.  
EMS Medical Director

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: 01/01/03

SUBJECT: AIRWAY OBSTRUCTION (Foreign Body)

POLICY NUMBER: 9110

BLS	ALS
<p>American Heart Association/American Red Cross procedures for conscious/unconscious patient for appropriate age group.</p> <p><b>Once obstruction is removed:</b> Monitor respiratory/circulatory status Give oxygen and/or ventilate prn.</p>	<p><b>Losing Consciousness/Unconscious</b></p> <p><b>SO</b> Direct laryngoscopy and Magill forceps If unsuccessful, alternate BLS procedures with ALS (laryngoscopy/Magills) while enroute to hospital.</p>
<p><b>PEDIATRIC NOTE:</b> Consider the possibility of croup and epiglottitis. If epiglottitis is suspected, keep patient in sitting position and do not attempt to visualize the oropharynx; immediate transport.</p>	

APPROVAL:

  
\_\_\_\_\_  
Bruce E. Haynes, M.D.  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 04/16/12

SUBJECT: ALLERGIC REACTION/ANAPHYLAXIS

POLICY NUMBER: 9120

<u>BLS</u>	<u>ALS</u>
<p>Ensure patent airway, give oxygen and/or ventilate prn. Monitor O2 saturation prn Assist ventilations with Bag Valve Mask when airway threatened</p> <p>Remove stinger</p> <p><b>For respiratory distress or hypotension:</b> May assist patient with prescribed Epinephrine auto-injector Adult dose: 0.3 mg Child/Infant dose: 0.15 mg</p> <p><b><u>ONE TIME ONLY</u></b> BH Contact required prior to any repeat dose</p> <p><b>If patient does not have auto-injector available, transport immediately.</b></p>	<p>Monitor ECG/Monitor O2 saturation prn</p> <p><b>SO</b> Insert ETT/Perilaryngeal (if airway threatened and patient losing consciousness or unconscious)</p> <p><b>SO</b> Establish IV prn</p> <p><b><u>ALLERGIC REACTION (Rash, urticaria)</u></b></p> <p><b>SO</b> Diphenhydramine 25 mg slow IVP or IM (if no IV); may repeat X1 to max 50 mg SO</p> <p><b><u>ALLERGIC REACTION ACUTE (respiratory distress, threatened airway, hypotension, mild angioedema):</u></b></p> <p><b>SO</b> Epinephrine (1:1,000) 0.3 mg IM; May repeat X1 q10 minutes SO</p> <p><b>SO</b> Diphenhydramine 50 mg slow IVP or IM (if no IV)</p> <p><b>SO</b> Nebulized Albuterol 2.5 mg (if wheezing persists after Epinephrine)</p> <p><b><u>ANAPHYLAXIS (severe hypotension, severe respiratory distress, cyanosis):</u></b></p> <p><b>SO</b> Epinephrine (1:1,000) 0.3 mg IM; May repeat X1 q10 minutes SO</p> <p><b>SO</b> Give IV fluids for hypotension; titrate fluid infusion to a systolic BP &gt; 90.</p> <p><b>SO</b> Diphenhydramine 50 mg slow IVP or IM (if no IV)</p> <p><b>SO</b> Nebulized Albuterol 5 mg (if wheezing persists after Epinephrine)</p> <p><b>BH</b> Epinephrine (1:10,000) 0.1 mg slow IVP</p> <p><b>If patient still presents with profound hypotension after Epinephrine and fluids</b></p> <p><b>BH</b> Consider Dopamine 400 mg/250 mL NS at 5-20 mcg/kg/min; titrate to systolic BP 90 mm Hg</p>

IMPERIAL COUNTY EMERGENCY MEDICAL SERVICES AGENCY  
POLICY/PROCEDURE/PROTOCOL

PAGE: 2 of 2

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 04/16/12

SUBJECT: ALLERGIC REACTION/ANAPHYLAXIS (continued)

POLICY NUMBER: 9120

<u>BLS</u>	<u>ALS</u>
	<p><b><u>PEDIATRIC NOTE:</u></b></p> <p><b>Refer to Pediatric Medication Guide</b></p> <p><b>SO</b> Nebulized Albuterol 2.5 mg (if wheezing persists after Epinephrine)</p> <p><b>SO</b> Normal Saline 20 mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</p> <p><b>BH</b> Diphenhydramine dosage as per pediatric medication guide slow IVP or IM (if no IV)</p> <p><b>BHP</b> Epinephrine (1:1,000) dosage as per pediatric medication guide; May repeat per BHP</p> <p><b>BHP</b> Dopamine 200 mg/250 mL NS, run at 5-20 mcg/kg/min</p>

APPROVAL:



\_\_\_\_\_  
Bruce E. Haynes, M.D.  
EMS Medical Director

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: ALTERED NEUROLOGIC FUNCTION (NON-TRAUMATIC)

POLICY NUMBER: 9130

<p style="text-align: center;"><b><u>BLS</u></b></p> <p>Ensure patent airway, monitor O2 saturation prn, give oxygen (Saturation &lt;94%) and/or ventilate prn. Position patient as follows:     If conscious with suspected CVA, elevate head 20-30 degrees     If unconscious, place patient lateral recumbent Immobilize spine if indicated <b><u>HYPOGLYCEMIA (suspected)</u></b> If patient is awake, has a gag reflex and can swallow: Give oral glucose solutions to include:     fruit juices, 2-3 packets of granulated sugar dissolved in liquid,     glucopaste on tongue depressor placed between cheek and gum, glucose tablets: 2-3 tablets, repeat as needed <b><u>SEIZURES</u></b> Protect from injury Treat associated injuries <b><u>Febrile seizures (pediatric)</u></b> Remove clothing Avoid shivering</p>	<p style="text-align: center;"><b><u>ALS</u></b></p> <p>Glucometer Monitor ECG/monitor O2 saturation prn SO Establish Saline lock/IV prn <b><u>HYPOGLYCEMIA</u></b> (Symptomatic patient with altered LOC or insufficient response to oral glucose preparations) SO Dextrose 50% 25 gm IV if BS level &lt; 60 mg/dL or unobtainable; may repeat per SO     <b>OR</b> SO Glucagon 1 mg IM if no IV and BS level &lt; 60 mg/dL or unobtainable <b><u>SEIZURES</u></b> <b>For generalized seizures that last longer than 5 min., seizures that cause respiratory compromise, or generalized seizures that are recurrent without lucid interval:</b> SO Midazolam 0.1 mg/kg slow IV (1 mg/min) to max 5 mg (discontinue if seizure stops); may repeat X 1 in 10 min. per SO <b><u>OR</u></b> SO Midazolam 0.2 mg/kg IM (2-3 mL increments) to max 10 mg; may repeat X 1 in 10 min. per SO <b><u>OR</u></b> SO Midazolam 0.2 mg/kg IN (2-3 mL increments) to max 10 mg; may repeat X 1 per BH <b><u>PEDIATRIC NOTE:</u></b> SO <b>Refer to Pediatric Drug Guide</b></p>
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**SUSPECTED CEREBROVASCULAR ACCIDENT** Important: document time of onset of symptoms. If possible take witness who can establish onset to hospital.

Patients exhibiting any of the signs/symptoms of stroke which started within the previous four hours may be experiencing an acute stroke. Assess for signs of obvious asymmetry:

- Check for facial droop/asymmetry (ask patient to show their teeth or to smile - observing for asymmetry)
- Assess for motor weakness or paralysis (have patient extend both arms - observe for weakness / have patient perform hand grasps - assess grip strength)
- Check for speech abnormalities (observe for slurring or inappropriate words)

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: ALTERED NEUROLOGIC FUNCTION (NON-TRAUMATIC)

POLICY NUMBER: 9130

The Los Angeles Prehospital Stroke Screen (LAPSS) is useful to evaluate acute, non-comatose, non-traumatic neurologic complaints. It is based on six criteria - if all are checked "yes", or ("unknown") the patient has a high likelihood of having an acute stroke.

**LAPSS Criteria:**

- Age > 45 years
- History of seizures or epilepsy absent
- At baseline, patient is not wheelchair bound or bedridden
- Blood glucose between 60 and 400
- Obvious asymmetry (right versus left) in any of the following categories (must be unilateral):
  - \* Facial smile/grimace
  - \* Grip
  - \* Arm strength
- Duration of signs/symptoms < 24 hours

**Disposition:**

Patients with a high likelihood of an acute stroke should be transported to the appropriate receiving hospital with a functioning CT scanner.

**Alert receiving hospital early if patient meets stroke screen criteria.**

APPROVAL:



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Bruce E. Haynes, M.D.  
EMS Medical Director

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: BEHAVIORAL EMERGENCIES

POLICY NUMBER: 9140

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Ensure patent airway, monitor O2 saturation prn, give oxygen and/or ventilate prn Nothing by mouth Attempt to determine if illness, injury, or drug use as cause Consider Altered Neurologic Function Policy # 9120 Restrian only if necessary to prevent injury (enlist support) No compression of chest and neck Restrain on side or supine (never prone or hog-tied) TASER® probes should be treated as impaled objects and not removed unless they are affecting the airway, may prevent life saving treatment or BH is consulted Consider law enforcement support (possible 5150)</p>	<p>Glucometer Monitor ECG/Monitor O2 Saturation prn <b>SO</b> Establish Saline lock/IV prn</p> <p><b><u>For Patients Exhibiting Severe Agitation:</u></b></p> <p><b>SO</b> Midazolam 0.2mg/kg IM (2-3 mL increments) to a max of 10 mg; May repeat X 1 per BH.</p> <p><b><u>OR</u></b> <b>SO</b> Midazolam 0.2mg/kg IN to a max of 5 mg; May repeat X 1 per BH. <b><u>OR</u></b> <b>SO</b> Midazolam 0.1 mg/kg slow IVP to max 5 mg; May repeat X 1 per BH.</p> <p><b>Note:</b> For severely agitated patients IN or IM Midazolam is the preferred route due to risk of injury to patient and/or to EMS personnel. Monitor BP and level of sedation every 5 minutes titrating to lowest dose possible. Maintain O2 saturation &gt;94%. Monitor ECG on all patients who have been exposed to TASER® Non-lethal devises. Treat probes as contaminated sharps. If TASER® probe <u>wires</u> need to be removed to facilitate transport simply cut wires with trauma shears</p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: BURNS

POLICY NUMBER: 9150

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Move patient to a safe environment Break contact with causative agent Ensure patent airway, monitor O<sub>2</sub> saturation, give oxygen and/or ventilate prn. Treat other injuries</p>	<p>Monitor ECG/Monitor O<sub>2</sub> saturation prn. <b>SO</b> Establish IV prn <b>SO</b> Morphine Sulfate 2-10 mg in 2 mg increments slow IV; may repeat per BH; titrate to pain relief, BP ≥ 90, and O<sub>2</sub> saturation &gt; 94%</p>
<p><b><u>THERMAL BURNS</u></b> Burns &lt; 10% BSA - cool saline soaks; Stop burning process with- non-chilled water or saline Burns 10% or greater - cover with dry dressings and keep warm</p>	<p><b>For patients with ≥20% 2nd or ≥5% 3rd degree burns and ≥ 15 years</b> <b>SO</b> Normal Saline 500 ml fluid bolus IV, then TKO</p>
<p><b><u>CHEMICAL BURNS</u></b> Brush off dry chemicals Flush with copious amounts of water See Poisoning (Absorbed) Policy # 9230</p>	<p><b><u>RESPIRATORY BURNS (for wheezing)</u></b> <b>SO</b> Nebulized Albuterol 5 mg; may repeat SO</p>
<p><b><u>TAR BURNS</u></b> Cool with water; Do not attempt to remove tar</p>	<p><b><u>PEDIATRIC NOTE:</u></b> <b>Refer to Pediatric Drug Guide</b> <b>SO</b> For fluid replacement Refer to Pediatric Drug Guide <b>BH</b> Morphine IV; may repeat per BHP</p>
<p><b>DISPOSITION:</b> STAT transport for critical burns (e.g., 2nd or 3rd degree burns involving &gt; 20% BSA, suspected respiratory involvement, significant burns to face, hands, feet, perineum, chemical or electrical burns). Patients meeting previous criteria will be transported directly to the nearest burn center. Burn patients meeting critical trauma criteria will be transported to the nearest trauma center.</p>	

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: **CARDIAC ARREST (non-traumatic)**

POLICY NUMBER: 9160

<u><b>BLS</b></u>	<u><b>ALS</b></u>
<p>Perform CPR, rate of at least 100 compressions per minute without interruption (compressions/ventilations 30:2 without interruption)</p> <p>Ensure patent airway, monitor O<sub>2</sub> saturation, give oxygen and/or ventilate via BVM prn</p> <p>Remove dermal NTG</p> <p><b>SO</b> AED (defibrillate in accordance with Policy #7210)</p> <p><b>SO</b> Insert Perilaryngeal Airway, after 3 rounds of 2 min. CPR*</p> <p>*Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p> <p><b>If hypovolemia suspected:</b> Immediate transport.</p> <p>If applicable refer to: Determination of Death in the Field Policy # 4140 Do Not Resuscitate Policy # 4150</p>	<p>Monitor ECG/Monitor O<sub>2</sub> saturation prn.</p> <p><b>SO</b> Perform defibrillation if indicated (in accordance with Policy #7200)</p> <p><b>SO</b> Insert ETT/Perilaryngeal Airway Monitor ETCO<sub>2</sub> (35-45 mmhg)</p> <p><b>SO</b> Establish IV TKO <b>Refer to specific dysrhythmia protocol</b></p> <p><b>If hypovolemia suspected:</b> Immediate transport</p> <p><b>SO</b> Establish IV enroute run wide open to max 2 liters</p> <p><b><u>PEDIATRIC NOTE:</u></b> <b>Refer to Pediatric Drug Guide</b></p> <p><b>If hypovolemia suspected:</b> <b>SO</b> Normal Saline 20 mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: CHEST PAIN (Suspected Cardiac Origin)

POLICY NUMBER: 9170

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Ensure patent airway, monitor O2 saturation, give oxygen and/or ventilate to a target saturation of 94% prn.</p> <p>Do not allow patient to walk or exert self</p> <p>May assist patient with prescribed Nitroglycerin 0.4 mg (1/150 gr) sublingual if BP &gt; 100 systolic</p>	<p>SO Monitor ECG; Obtain 12 lead if available and report STEMI findings; Monitor O2 saturation</p> <p>SO Establish IV TKO</p> <p>SO Treat dysrhythmias per specific protocol</p> <p>SO Nitroglycerin 0.4 mg (1/150 gr) SL q 5 min. X 3 if BP ≥ 90 systolic (*AEMT if BP ≥ 100 systolic) additional NTG per BH</p> <p>SO Aspirin 162 mg chewable PO</p> <p>SO Morphine Sulfate 2-20 mg in 2 mg increments IVP; titrate to pain relief</p> <p><b><u>HYPOTENSION (suspected Cardiogenic Shock)</u></b></p> <p>SO Fluid challenge 250 mL with clear lungs; may repeat per BH</p> <p>BH Dopamine 400 mg/250 mL NS, run at 5-20 mcg/kg/min IV; titrate to systolic BP 90-100 mmhg</p> <p><b>NOTE:</b></p> <p>Ask patients who are candidates for nitroglycerin if they are on erectile dysfunction medications and, if so, the dose and time last taken. No nitroglycerin should be given under standing orders to a patient who has taken erectile dysfunction medications within the last 48 hours. If Base contact cannot be made and a patient is experiencing chest pain who has taken erectile dysfunction medication in the last 48 hours and IV line should be started and small doses of morphine (2 mg increments) should be given and titrated to pain relief with necessary fluid</p>
<p><b>NOTE:</b> For suspected thoracic aortic aneurysm, transport immediately.</p>	

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: DYSRHYTHMIAS

POLICY NUMBER: 9180

<u>BLS</u>	<u>ALS</u>
Ensure patent airway/Monitor O2 saturation prn. Give oxygen Ventilate prn.	<p><b>Cardiac dysrhythmias are treated only if they are causing or have the potential to cause unstable condition or severe patient distress.</b></p> <p>Monitor ECG - if stable, obtain 12-lead if available; report results/Monitor O2 saturation prn.</p> <p><b>SO</b> Establish IV TKO (Antecubital site and large bore are <u>required</u> for Adenosine Administration)</p> <p><b><u>SUPRAVENTRICULAR TACHYCARDIA (SVT)</u></b></p> <p><b>SO</b> Valsalva's maneuver</p> <p><b>SO</b> Adenosine 6 mg IV followed immediately by 20 ml NS IV</p> <p><b>BH</b> If no response, may repeat after 3-5 minutes Adenosine 12 mg IV followed immediately by 20 ml NS IV</p> <p><b><u>ATRIAL FIBRILLATION / ATRIAL FLUTTER STABLE</u></b></p> <p><b>BH</b> CaCL 10% 5 mL slow IV (if BP &lt; 100 systolic)</p> <p><b>BH</b> Verapamil 5 mg slow (over 2-3 minutes) IV; may repeat to max 15 mg in 30 min. per BH titrate medication administration to a SBP &gt;90 mmHg</p> <p><b><u>UNSTABLE</u></b> (chest pain, BP &lt; 90 systolic, decreased LOC, CHF)</p> <p><b>BH</b> Midazolam 1-2 mg slow IV (1 mg/min) prn. pre-cardioversion, may use Intra-Nasal administration; use with caution in SBP 80 - 90 mmHg</p> <p><b>BH</b> Synchronized cardioversion at manufacturer's recommended energy dose; May repeat X 3 per BH</p> <p style="text-align: center;"><b>NOTE</b> PSVT and Atrial Flutter often respond to lower energy levels, start at 50 joules.</p>

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9180

<u>BLS</u>	<u>ALS</u>
	<p><b><u>PEDIATRIC NOTE:</u></b></p> <p>If UNSTABLE SVT, additional signs of poor perfusion include cyanosis, mottled skin, delayed capillary refill, altered LOC, dyspnea, diminished or absent peripheral pulses with the following heart rates:</p> <ul style="list-style-type: none"><li>Premie - 3 yrs &gt; 240 bpm</li><li>4 yrs or older &gt; 200 bpm</li></ul> <p><b>Refer to Pediatric Drug Guide</b></p> <p><b>BHP</b> Midazolam IVP prn. pre-cardioversion</p> <p><b>BHP</b> Synchronized cardioversion at 1 J/kg; may repeat with 2 J/kg, 4 J/kg, 4 J/kg per BHP (Contraindicated if unable to deliver &lt; 4 J/kg)</p>

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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9181

<u>BLS</u>	<u>ALS</u>
Ensure patent airway Give oxygen Ventilate prn. Monitor O2 saturation prn.	Monitor ECG/Monitor O2 saturation prn. If stable Perform 12 lead ECG if available and report findings <b>SO</b> Establish IV TKO
	<b><u>UNCOMPENSATED BRADYCARDIAS WITH PULSE</u></b> (Clinical manifestations include chest pain, shortness of breath, decreased LOC, BP < 90 systolic, pulmonary congestion)  <b>SO</b> Normal Saline 250 mL fluid bolus IV with clear lungs; may repeat to maintain BP ≥ 90 <b>SO</b> Atropine Sulfate 0.5 mg IV, may repeat per BH q 5 min. to max 3 mg <b>SO</b> Transcutaneous pacing <b>For discomfort caused by TCP (mechanical capture and SBP ≥100):</b> <b>SO</b> Morphine Sulfate 2-20 mg IV in 2 mg increments, titrate to pain relief and SBP ≥ 90 <b>For discomfort not relieved by Morphine Consider:</b> <b>SO</b> Midazolam 1-5 mg slow IV (1 mg/min); titrate to pain relief; minimum SBP ≥ 80 <b>BH</b> Dopamine 400 mg/250 mL NS at 5-20 mcg/kg/min IV drip; titrate to cardiac rate/rhythm response and SBP ≥ 90  <b>NOTE:</b> If heart rate increases to greater than 60/min and BP < 90 systolic, treat as Cardiogenic Shock. For complete heart block or Mobitz II with wide ventricular response, go directly to TCP

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9181

BLS	ALS
	<p><b><u>PEDIATRIC NOTE:</u></b></p> <p>Unstable bradycardias are usually the result of hypoxia or severe shock in pediatrics - not cardiac abnormality. Additional signs of poor perfusion include cyanosis, mottled skin, dyspnea, delayed capillary refill, altered LOC, diminished or absent peripheral pulses, and may be caused by the following heart rates:</p> <p style="padding-left: 40px;">Infant/Child (&lt; 9 years) &lt; 60 bpm Child (9-14 yrs) &lt; 40 bpm</p> <p style="text-align: center;"><b>Refer to Pediatric Drug Guide</b></p> <p><b>SO</b> Normal Saline 20 mL/kg IV initial bolus via Volutrol; may repeat per SO X2</p> <p><b>BHP</b> Atropine 0.02 mg/kg to a max of 0.5mg; Maximum total dose of 2mg</p> <p><b>BHP</b> Dopamine 200 mg/250 mL NS, run at 5-20 mcg/kg/min</p>

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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9183

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Ensure patent airway Give oxygen Ventilate prn. Monitor O2 saturation prn.</p>	<p>Monitor ECG/Monitor O2 saturation prn. <b>SO</b> Establish IV TKO <b>VENTRICULAR TACHYCARDIA (or wide-complex tachycardia of uncertain type)</b> <b><u>STABLE</u></b> <b>SO</b> Lidocaine 1.0-1.5 mg/kg slow IVP <b>SO</b> Repeat dose of Lidocaine 0.5-0.75 mg/kg slow IVP every 5-10 min. until patient converts or to max 3 mg/kg if needed <b><u>UNSTABLE (BP &lt; 90 systolic, dyspnea, chest pain, altered LOC, pulmonary edema)</u></b> <b>SO</b> Midazolam 1-2 mg slow IVP (1 mg/min) prn. pre-cardioversion; minimum SBP ≥ 80 Midazolam 1 mg if age 60 or above; minumim SBP ≥ 80 <b>SO</b> Synch. cardioversion at manufacturer's recommended energy dose; May repeat per BH <b>BH</b> Repeat cardioversion as needed <b><u>NOTE:</u></b> Perform unsynchronized cardioversion if patient is unconscious or if monitor does not sync. Automated Implantable Cardioverter Defibrillator &gt; 1 shock causing discomfort, lidocaine and pain medication prn. <b><u>POST CONVERSION (if heart rate &gt; 50/min)</u></b> <b>SO</b> Lidocaine 1.0-1.5 mg/kg slow IVP (if not already given) <b>SO</b> Repeat dose of Lidocaine 0.5-0.75 mg/kg slow IVP q 5-10 min. to max 3 mg/kg if needed <b><u>PEDIATRIC NOTE:</u></b> <p style="text-align: center;"><b>Refer to Pediatric Drug Guide</b></p></p>

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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: Rev. 4/16/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9184

<u>BLS</u>	<u>ALS</u>
<p>Begin CPR , after first 30 compressions give fist ventilations and continue until ready to defibrillate</p> <p>AED if available</p> <p>Assist ventilations</p> <p>Monitor O2 saturation prn.</p> <p>*Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p>	<p>If unwitnessed, perform CPR x2 min. prior to defibrillation (if witnessed by EMS, perform CPR until ready to defibrillate)</p> <p><b><u>VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA</u></b></p> <p>Monitor ECG/Monitor O2 saturation prn.</p> <p><b>SO</b> Defibrillate at max setting x1 at manufacturer's recommended energy dose</p> <p>Perform CPR x2 minutes immediately after shock</p> <p>Perform max. 10 second rhythm check (perform pulse check only if perfusing rhythm)</p> <p><b>SO</b> Defibrillate at max setting x1 if indicated for persistent VF/Pulseless VT</p> <p>After each shock, continue with sequence of CPR x2 minutes &amp; rhythm check until patient converts</p> <p><b>SO</b> Establish IV TKO, do not interrupt CPR to start IV</p> <p><b>SO</b> Epinephrine (1:10,000) 1 mg IV during CPR, may repeat q 3-5 min., OR (1:1,000) 2 mg in 8 cc NS ETT X I (if no IV)</p> <p><b>SO</b> After each drug, continue with sequence of CPR x2 minutes, rhythm/pulse check and shock prn until patient converts</p> <p><b>SO</b> Insert ETT/Perilaryngeal Airway (once airway is in place ventilate patient at a rate of 8-10 breaths/min)</p> <p><b>SO</b> EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg)</p> <p><b>SO</b> If return of pulses obtain 12-Lead ECG if available</p> <p><b>Note:</b> For patients with an EtCO2 reading of less than 10mm/Hg or patients in nonperfusing rhythms after resuscitative effort, consider early Base Hospital contact for disposition/pronouncement at scene.</p> <p><input type="checkbox"/> Flush IV line with N.S. after medication administration. Medication should be administered as soon as possible after rhythm checks.</p> <p><input type="checkbox"/> CPR ratio 30:2 compressions to ventilations (compression rate of 100/min) until patient is intubated, then ratio becomes 10:1.</p> <p><b><u>PEDIATRIC NOTE:</u></b></p> <p>Refer to Pediatric Drug Guide</p>

APPROVAL:

  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9185

<u>BLS</u>	<u>ALS</u>
<p>Perform CPR and apply AED prn. (CPR Ratio 30:2 compressions to ventilations until patient is intubated; After intubation ratio 10:1.) Assist ventilations prn. Monitor O2 saturation prn.</p> <p>*Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p>	<p>Monitor ECG/Monitor Oxygen Saturation prn.</p> <p><b><u>PULSELESS ELECTRICAL ACTIVITY (PEA)</u></b></p> <p><b>SO</b> Establish IV TKO (Do not interrupt CPR to establish IV)</p> <p><b>SO</b> Insert ETT/Perilaryngeal</p> <p>Consider possible causes: hypovolemia, hypoxia, tension pneumothorax, drug overdose, hyperkalemia, cardiogenic shock. Treat underlying problem in accordance with appropriate protocol.</p> <p><b>SO</b> Epinephrine (1:10,000) 1 mg IVP, may repeat q 5 min., OR Epinephrine (1:1,000) 2 mg in 8 cc NS ETT X 1 (if no IV)</p> <p><b>SO</b> Consider fluid challenge 250-500 mL NS (if clear lungs); additional fluids per BH</p> <p><b>BH</b> Consider Dopamine 400 mg/250 mL NS, run at 10-20 mcg/kg/min</p> <p><b>SO</b> EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg)</p> <p><b><u>PEDIATRIC NOTE:</u></b></p> <p><b>SO</b> Refer to Pediatric Drug Guide Fluid challenge NS 20 mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</p> <p><b>BH</b> Dopamine 200 mg/250 mL NS, run at 5-20 mcg/kg/min</p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: Rev. 4/16/12

SUBJECT: DYSRHYTHMIAS (continued)

POLICY NUMBER: 9186

<u>BLS</u>	<u>ALS</u>
<p>Perform CPR and apply AED prn. (CPR Ratio 30:2 compressions to ventilations until patient is intubated; After intubation ratio 10:1.) Assist ventilations prn. Monitor O2 saturation prn.</p> <p>*Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p>	<p><u>ASYSTOLE</u></p> <p><b>SO</b> Monitor ECG/Monitor Oxygen Saturation prn.</p> <p><b>SO</b> Establish IV</p> <p><b>SO</b> Epinephrine (1:10,000) 1mg IV, may repeat q 5 min.</p> <p><b>SO</b> Insert ETT/Perilaryngeal Airway</p> <p><b>SO</b> EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg)</p> <p><b>NOTE:</b> If patient remains in asystole or other agonal rhythm after successful intubation and medications and no reversible causes are identified, consider termination of resuscitative efforts by BH Physician.</p> <p><u>PEDIATRIC NOTE:</u> Refer to Pediatric Drug Guide</p>

APPROVAL:

  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: ENVIRONMENTAL EMERGENCIES

POLICY NUMBER: 9190

<u>BLS</u>	<u>ALS</u>
<p>Remove patient from hostile environment Ensure patent airway Give oxygen and/or ventilate prn. Monitor O2 saturation prn.</p> <p><b><u>COLD EXPOSURE:</u></b> Remove wet clothing Handle patient gently and avoid unnecessary movement Institute gentle warming with blankets or warm packs Do not apply heat directly to the skin or rub the injured areas Apply dressings to blistered or necrotic areas Prolonged CPR may be indicated If alert, give warm fluids; if altered LOC - NPO</p> <p><b><u>HEAT EXHAUSTION:</u></b> Loosen or remove clothing Cool gradually (spraying with tepid water and fanning); avoid shivering If conscious and no nausea, give small amounts of cool liquids</p> <p><b><u>HEAT STROKE:</u></b> Rapid cooling: remove clothing Ice packs to axillae, groin, cervical area (avoid pressure on carotids) Flush or spray with tepid water, fan patient Avoid shivering *Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p>	<p>Monitor ECG/Monitor O2 saturation prn.</p> <p>SO Establish Saline lock/IV prn. SO Insert ETT/Perilaryngeal Airway prn. SO EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg) prn.</p> <p><b><u>HEAT EXHAUSTION/STROKE:</u></b> SO Consider fluid challenge of 500 mL NS (if clear lungs) May repeat per SO, limit 2 liters</p> <p><b><u>HYPOTHERMIA (with cardiac arrest)</u></b> SO Hold medications SO Provide CPR prn. SO For severe hypothermia limit shock to 1, and no medications</p> <p><b><u>PEDIATRIC NOTE:</u></b> SO Establish Saline lock/IV prn. SO Normal Saline 20 mL/kg initial bolus via Volutrol; may repeat per BH</p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: 6/1/07 rev.

SUBJECT: HEMODIALYSIS

POLICY NUMBER: 9200

BLS	ALS
<p>Ensure patent airway Give oxygen and/or ventilate prn.</p>	<p>SO Monitor ECG Establish IV TKO (preferably in arm without graft/AV fistula) NOTE: In life-threatening conditions, if unable to start IV elsewhere, may access graft/fistula.</p> <p><b>SUSPECTED HYPERKALEMIA (widened QRS, peaked T waves, bradycardia)</b></p> <p>SO Calcium Chloride 250-500 mg IVP SO Dextrose 50% 25 gm IVP</p> <p><b>PEDIATRIC NOTE:</b> Refer to Pediatric Drug Guide</p>

APPROVAL:

  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: NEAR DROWNING

POLICY NUMBER: 9210

<p style="text-align: center;"><b><u>BLS</u></b></p>	<p style="text-align: center;"><b><u>ALS</u></b></p>
<p>Ensure patent airway, suction prn.</p> <p><b>SO</b> *Insert Perilaryngeal Airway prn.</p> <p>Monitor O2 saturation prn.</p> <p>Give oxygen and/or ventilate prn.</p> <p>Spinal immobilization for suspected spinal injury</p> <p>Keep patient warm</p> <p>All patients in this category should be evaluated in the hospital.</p> <p>*Perilaryngeal Airway may only be utilized by authorized EMT-I, or Advanced EMT, who have EMT-I Optional Skill Accreditation.</p>	<p>Monitor ECG/Monitor O2 saturation prn.</p> <p><b>SO</b> Insert ETT/Perilaryngeal Airway prn.</p> <p><b>SO</b> EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg) prn.</p> <p><b>SO</b> Establish Saline lock/IV prn.</p> <p><b>SO</b> Consider nebulized Albuterol 2.5 mg for wheezing; may repeat per BH</p> <p><b>BH</b> CPAP at 5-10cm H2O in cooperative and alert patients</p> <p><b><u>PEDIATRIC NOTE:</u></b></p> <p style="text-align: center;"><b>Refer to Pediatric Drug Guide</b></p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: OBSTETRICAL EMERGENCIES

POLICY NUMBER: 9220

**BLS**

Ensure patent airway, give oxygen and/or ventilate prn.  
Monitor O2 saturation prn.  
If delivery not imminent, transport immediately on left side  
(if greater than 16 weeks gestation)  
Any birth that is difficult or not progressing, transport immediately

**ROUTINE DELIVERY:**

If no time for transport, proceed with delivery  
If unbroken amniotic sac, puncture sac away from baby's face  
If cord around neck, slip over head; if unable: clamp and cut cord  
Suction baby's mouth then nose (only for obvious obstruction); PRN  
Positive Pressure Ventillation, PRN if HR <100 BPM  
Stimulate baby by tapping soles of feet and/or rubbing back  
Clamp and cut cord once it stops pulsating (1 min after delivery);record time  
Dry baby, wrap warmly and place to mother's breast  
Assess APGAR at 1 min. and at 5 min.  
Do not wait on scene to deliver placenta  
Once placenta is delivered, massage the fundus  
Save placenta and deliver with patient to hospital  
Place identification bands on mother and infant

**ALS**

SO Monitor EKG/Monitor O<sub>2</sub> saturation prn.  
SO Establish Saline lock/IV prn. (mother)

**MECONIUM STAINING**

SO For depressed infant (weak resp. effort, poor muscle tone, HR  $\leq$  100) perform tracheal suctioning  
Suction trachea as needed (past cords) under direct visualization with laryngoscope  
using 12-14 Fr catheter until heavy meconium is cleared.  
Limit suctioning intervals to 5 seconds and monitor for bradycardia.

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: OBSTETRICAL EMERGENCIES (continued)

POLICY NUMBER: 9220

<u>BLS</u>	<u>ALS</u>
<p><b><u>BLEEDING DURING PREGNANCY:</u></b> Immediate transport. Place pad to perineum. Treat for shock Bring tissue/fetus to hospital</p> <p><b><u>PRE-ECLAMPSIA, ECLAMPSIA:</u></b> Immediate transport, avoid sirens/excessive stimulation Treat seizures per Altered Neurologic Function Protocol</p> <p><b><u>BIRTH COMPLICATIONS:</u></b></p> <p><b><u>Prolapsed Cord</u></b> Place mother in head down position with hips elevated on pillows Insert gloved hand into the vagina and gently push presenting part off the cord. Do not handle or push cord back in vagina. Transport immediately while retaining this position until relieved by hospital personnel.</p> <p><b><u>Post Partum Hemorrhage</u></b> Massage fundus Treat for shock, place pad to vagina (do not pack vagina) Immediate transport</p>	<p><b><u>POST PARTUM HEMORRHAGE</u></b></p> <p><b>SO</b> 500 ml fluid bolus N.S. and titrate to vital signs. Treat for shock, additional fluids per BH.</p> <p><b><u>ECLAMPSIA (SEIZURES)</u></b></p> <p><b>SO</b> Midazolam 0.1 mg/kg slow IV/IO (1 mg/min) to max 5 mg (discontinue if seizure stops); may repeat X 1 per BH</p> <p><b>OR</b></p> <p><b>SO</b> Midazolam 0.2 mg/kg IM (2-3 mL increments) to max 10 mg; may repeat X 1 per BH</p> <p><b>OR</b></p> <p><b>SO</b> Midazolam 0.2 mg/kg IN (2-3 mL increments) to max 10 mg; may repeat X 1 per BH</p>

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: OBSTETRICAL EMERGENCIES (continued)

POLICY NUMBER: 9220

**BLS**

**ALS**

**BIRTH COMPLICATIONS (continued)**

**Breech Birth**

Immediate transport with mother in head down, hips elevated position  
Allow infant to deliver to the waist  
Once legs and buttocks are delivered, the head can be assisted out  
If head does not deliver within 3 min., insert gloved hand and  
create an airway for the infant.  
Do not try to pull baby's head out  
Place mother on high flow oxygen

**Hand/arm presentation**

Delivery should not be attempted in the field  
Immediate transport with mother in head down, hips elevated position  
Place mother on high flow oxygen

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 03/08/12

SUBJECT: OBSTETRICAL EMERGENCIES (continued)

POLICY NUMBER: 9220

<u>BLS</u>	<u>ALS</u>
<p><b><u>PREMATURE AND/OR LOW BIRTH WEIGHT INFANTS</u></b> Resuscitate as needed Wrap baby in blanket and place on mother's abdomen Suction baby's mouth and nose prn (for obvious airway obstructions) Give oxygen Immediate transport Monitor O2 saturation prn. <b><u>NEONATAL RESUSCITATION:</u></b> After initial care of newborn to include drying and tactile stimulation; if newborn has:     1) Apnea or gasping respirations     2) Heart rate &lt; 100 bpm Begin BVM ventilations with room air at 40-60 breaths/min Reassess breathing effort after 30 sec. If, despite adequate ventilation:     1) heart rate &lt; 60 bpm after 30 seconds Begin chest compressions at rate of 90/min interposed with ventilations 30/min until spontaneous HR 100/min or greater Assess APGAR score Continue resuscitation prn. and immediate transport if no ALS</p>	<p><b><u>NEONATAL RESUSCITATION:</u></b>  Monitor ECG of newborn/Monitor O2 saturation prn.  <b>For asystole or spontaneous heart rate &lt; 60 bpm despite adequate ventilation or CPR:</b> <b>SO</b> Epinephrine (1:10,000) IV (see drug chart for dose); may repeat per BH Continue with treatment per separate dysrhythmia protocol <b>BH</b> Normal Saline 10mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</p>

APPROVAL:



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EMS Medical Director

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: POISONING

POLICY NUMBER: 9230

<u>BLS</u>	<u>ALS</u>
<p>Safety first, take precautions to prevent exposure Isolate the area (if applicable) Notify the appropriate agencies if HAZ/MAT</p> <p>Move victim(s) to safe environment Decontaminate (if applicable) Ensure patent airway, give oxygen and/or ventilate prn. Monitor O2 saturation prn. Contact poison control center as needed 1-800-411-8080</p>	<p>SO Monitor ECG/Monitor O2 saturation prn. SO Establish Saline Lock/IV prn.</p> <p><b><u>INGESTED POISONS</u></b></p> <p>SO Activated Charcoal 50 Gm PO (only if within 60 minutes of ingestion, if recommended by Poison control Center, and if transport time &gt; 30 minutes)</p> <p><b>NOTE:</b> Exceptions to activated charcoal administration: acids, alcohol, alkalies, petroleum distillates, caustic substances, iron or drugs that cause rapid onset of seizures (e.g., camphor, tricyclics).</p> <p><b><u>NARCOTIC (depressed respirations 12/min or less, pinpoint pupils, evidence of drug use)</u></b></p> <p>SO Naloxone 2 mg IM/IN (half dose each nostril) or 0.5 mg IVP; may repeat SO</p> <p>SO If patient unconscious and breathing ineffectively after Naloxone, consider intubation</p> <p><b>NOTE:</b> Use with caution in opioid dependent pain management patients.</p>
<p><b><u>SKIN CONTACT (isolated incident)</u></b></p> <p>Remove contaminated clothing, brush off powder, rinse with water for at least 20 min. Irrigate eyes for 20 min. NOTE: Ensure poison does not react violently with water.</p>	<p><b><u>ORGANOPHOSPHATE POISONING</u></b></p> <p>SO Atropine 2 mg IV/IM; may repeat every 3 - 5 minutes until symptoms relieved (fewer secretions, easier to ventilate)</p> <p>SO Midazolam 0.1 mg/kg slow IV (1mg/min) to a max 5mg (discontinue if seizure stops); may repeat X1 in 10 minutes per BH</p> <p><b>OR</b></p> <p>SO Midazolam 0.2 mg/kg slow IM (2-3 mL increments) to a max 10 mg; may repeat X1 in 10 minutes per BH</p>

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: POISONING (continued)

POLICY NUMBER: 9230

BLS	ALS
<p><b><u>ENVENOMATION</u></b> Ensure patent airway, give oxygen and/or ventilate prn.</p> <p><b>Snake bite</b> Keep involved extremity immobile, at or slightly below heart level Mark proximal extent of swelling Remove jewelry prn. Keep patient calm, do not allow to walk</p> <p><b>Bee stings</b> Remove bee stinger by flicking or scraping with edge of card Apply cold compress to site</p> <p><b>Hyperthermia secondary to stimulant</b> initiate cooling measures</p> <p><b>Insect bites and Scorpion stings</b> Apply cold compress to site</p>	<p><b><u>SMOKE, GAS, TOXIC SUBSTANCE INHALATION</u></b> SO Consider nebulized Albuterol 2.5 mg (give 5 mg for severe distress); may repeat/continuous administration PRN SO</p> <p><b><u>TRICYCLIC OVERDOSE (altered LOC, tachycardia, prolonged QRS)</u></b> SO Hyperventilation if intubated</p> <p><b><u>EXTRAPYRAMIDAL REACTIONS</u></b> SO Diphenhydramine 25-50 mg IV/IM</p> <p><b><u>STIMULANT OVERDOSE</u></b> <b><u>Sudden hypoventilation, oxygen desaturation or apnea:</u></b> SO High flow O2 SO Ventilate prn SO N.S. 500 mL fluid bolus IV, may repeat per BH</p> <p><b><u>For severe agitation:</u></b> SO Midazolam 0.2 mg/kg IM to max dose 10 mg; may repeat X1 in 10 min per SO OR SO Midazolam 0.2 mg/kg IN to max dose 5 mg; may repeat X1 in 10 min per SO OR SO Midazolam 0.1 mg/kg IV to max dose 5 mg; may repeat X1 in 10 min per SO</p> <p><b><u>NOTE: For severely agitated patient IN/IM Versed is preferred route to decrease risk of injury to patient and EMS personnel</u></b></p> <p><b><u>PEDIATRIC NOTE:</u></b> Refer to Pediatric Drug Guide</p>

APPROVAL:



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OPERATIONS: **BLS/ALS TREATMENT PROTOCOLS**

DATE: Rev. 4/16/12

SUBJECT: **RESPIRATORY DISTRESS**

POLICY NUMBER: 9240

<u><b>BLS</b></u>	<u><b>ALS</b></u>
<p>Ensure patent airway, give oxygen and/or ventilate prn; maintain O2 saturation &gt;94%</p> <p>Monitor O2 saturation prn.</p> <p>Reassure patient</p> <p>May assist severe asthma patient BVM @ 6-10 breaths/min</p> <p><b>For respiratory distress with bronchospasm:</b></p> <p>May assist patient with prescribed inhaler</p> <p>Note: Does not include steroids or long-acting Serevent (Salmeterol, Pulmicort and Advair)</p>	<p>Monitor ECG/Monitor O2 saturation prn.</p> <p><b>SO</b> Insert ETT/Perilaryngeal prn.</p> <p><b>SO</b> EtCO2 monitoring (Waveform Capnography 35 - 45 mm/Hg)</p> <p><b>SO</b> Establish Saline lock/IV prn.</p> <p><b>RESPIRATORY DISTRESS WITH BRONCHOSPASM (suspected Asthma, COPD)</b></p> <p><b>SO</b> Albuterol 2.5 mg (give 5 mg for severe distress) via nebulizer; may repeat/continuous administration prn.</p> <p><b>SO</b> For severe respiratory distress - CPAP 5-10 cm H<sub>2</sub>O for alert patients</p> <p><b>Asthma only: If patient in severe distress and unable to use nebulizer:</b></p> <p><b>BH</b> Epinephrine 1:1000 0.3 mg IM (use with caution over 40 yrs, heart disease, or BP &gt; 150 systolic)</p>
<p><b><u>HYPERVENTILATION SYNDROME</u></b></p> <p>Remove from any causative environment</p> <p>Coaching/reassurance</p> <p>Do not use bag or mask rebreathing</p>	<p><b><u>RESPIRATORY DISTRESS OF SUSPECTED CARDIAC (CHF) ETIOLOGY</u></b></p> <p><b>SO</b> BP &gt; 150 systolic, Nitroglycerin 0.8 mg (two 1/150 gr) SL q 5 min. X 3 for severe distress <b>SO</b></p> <p><b>SO</b> BP ≥100- &lt;150 systolic, Nitroglycerin 0.4 mg (1/150 gr) SL q 5 min. X 3 <b>SO</b></p> <p><b>SO</b> For severe respiratory distress - CPAP 5-10 cm H<sub>2</sub>O; if tolerated by cooperative and alert patient</p> <p><b>BH</b> BP &lt; 90 systolic, consider Dopamine 400 mg/250 mL NS, run at 10-20 mcg/kg/min titrate to systolic BP 90-100 mm Hg</p> <p><b>BH</b> May repeat Nitroglycerin</p> <p><b><u>RESPIRATORY DISTRESS OF CROUP-LIKE COUGH</u></b></p> <p><b>SO</b> Aerosolized saline or water 5 mL via oxygen powered nebulizer/mask, may repeat prn</p> <p><b>For respiratory distress with stridor at rest suspected croup/epiglottitis (1-2 yr old patient 10-13kg):</b></p> <p><b>BHP</b> Epinephrine 1:1000 via nebulizer 0.5mL/kg max 5mL; monitor ECG during administration</p> <p><b><u>PEDIATRIC NOTE:</u></b></p> <p>Refer to Pediatric Drug Guide</p> <p><b><u>RESPIRATORY DISTRESS with bronchospasm</u></b></p> <p>For child weighing 20 kg or greater in severe distress - give albuterol 5 mg</p>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: 6/1/07 rev.

SUBJECT: SEXUAL ASSAULT

POLICY NUMBER: 9250

<b>BLS</b>	<b>ALS</b>
<p>Ensure patent airway, give oxygen and/or ventilate prn.</p> <p>For traumatic injuries, treat according to specific Trauma Protocol</p> <p>Do not allow patient to bathe or change clothing.</p> <p>Preserve all evidence and bring to hospital.</p> <p>Refer to Behavioral Emergencies Protocol if appropriate.</p>	<p><b>SO</b> Establish Saline lock/IV prn.</p>

APPROVAL:

  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS


DATE: 6/1/07 rev.

SUBJECT: SHOCK/HYPOTENSION (non-traumatic)

POLICY NUMBER: 9260

<b>BLS</b>	<b>ALS</b>
<p>Ensure patent airway, give oxygen and/or ventilate prn. Keep warm Nothing by mouth Remove dermal NTG prn. If not contraindicated, place patient supine with legs elevated</p> <p>NOTE: Do not use Trendelenberg position</p>	<p>Monitor ECG</p> <p><b>SO</b> Establish IV</p> <p><b>SO</b> For mild hypotension, give fluid bolus 250-500 mL NS; may repeat per BH order</p> <p><b>SO</b> For profound hypotension, run wide open to max 2 liters</p> <p>Run IVs to maintain systolic BP 90 mm Hg; additional fluids per BH order</p> <p><b>BH</b> Dopamine 400 mg/250 mL NS, run at 10-20 mcg/kg/min; titrate to systolic BP 90 mm Hg</p> <p>See Chest Pain Protocol for cardiogenic shock.</p> <p><b>PEDIATRIC NOTE:</b></p> <p><b>SO</b> Normal Saline 20 mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</p> <p><b>BHP</b> Dopamine 200 mg/250 mL NS, run at 5-20 mcg/kg/min</p>

APPROVAL:

  
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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: **TRAUMA**

POLICY NUMBER: 9270

<b><u>BLS</u></b>	<b><u>ALS</u></b>
Ensure patent airway, give oxygen and/or ventilate prn. Maintain spinal immobilization prn. (except penetrating trauma without deficit) Monitor O <sub>2</sub> saturation prn. Control external bleeding Keep patient warm Immediate transport if patient critical	Monitor ECG/Monitor O <sub>2</sub> saturation prn. <b>SO</b> Place tourniquet for uncontrolled bleeding despite direct pressure/dressing (2-4 inches from wound) <b>SO</b> Establish IV (preferably enroute). Adjust rate per vital signs; target systolic BP 80-90 mm Hg (except head trauma) Additional fluids per BH In severe injury or BP < 90 mmHg, establish IV en-route. 500 mL fluid bolus <b>SO</b> EtCO <sub>2</sub> monitoring prn.
<b><u>ABDOMINAL TRAUMA</u></b>	<b><u>HEAD TRAUMA</u></b>
Cover eviscerated bowel with saline soaked pads	<b>SO</b> If GCS less than or equal to 8, maintain SBP ≥ 100 with IV fluids
Flex hips and knees if not contraindicated	<b><u>CHEST TRAUMA</u></b>
<b><u>CHEST TRAUMA</u></b>	<b>BH</b> For suspected tension pneumothorax with hypotension and severe dyspnea, consider needle thoracostomy
Cover open chest wound with three-sided occlusive dressing; release dressing if suspected tension pneumothorax develops	<b><u>EXTREMITY TRAUMA</u></b>
<b><u>EXTREMITY TRAUMA</u></b>	<b>(Isolated extremity injury [including hip] in the presence of adequate vital signs and level of consciousness)</b>
Place tourniquet for uncontrolled bleeding despite attempts at controlling bleeding with direct pressure/dressing (2-4" from wound)	<b>SO</b> Morphine 5-10 mg in 5 mg increments; titrate to pain relief; may repeat as per BH
avoid placement over joint, fractures, stab or gun shot wound sites	<b><u>CRUSH INJURY (With extended compression &gt;2 hours of extremity or torso)</u></b>
Splint fractures as they lie if no neurovascular impairment	Note: Prior to release of compression administer the following in consultation with BH
Splint dislocations in position found	<b>SO</b> Give fluid bolus; 500ml N.S. IV, then TKO
Immobilize joints above and below injury, if possible	<b>BH</b> Calcium Chloride 250mg IV over 30 seconds
Fractures with neurovascular impairment may be realigned	
per BH with gentle, unidirectional traction before splinting	
If circulation is not restored after two attempts at	
straightening, splint as it lies and transport immediately	
Consider pelvis wrap for fractures	

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: **TRAUMA (continued)**

POLICY NUMBER: 9270

**BLS**

**TRAUMATIC ARREST**

Consider Determination of Death Protocol

If in doubt, initiate CPR

Assist ventilations with cervical in-line stabilization (if applicable)

See Policy #7210 and 7700 for use of AED and Perilaryngeal Airway

Consider discontinuing CPR for extended transport time

**IMPALED OBJECTS**

Immobilize (exceptions: may remove object if in face or neck and ventilation is compromised; if object interferes with CPR; or if object interferes with transport)

**AMPUTATED PARTS**

Place in plastic bag and keep cool during transport

Do not place in water or directly on ice

**OPEN NECK WOUNDS**

Cover with occlusive dressing

**ALS**

**TRAUMATIC ARREST**

**BHP** Consider discontinuing CPR in blunt trauma

**SO** Insert ETT/Perilaryngeal Airway with in-line stabilization if indicated (ventilate 8-10/min)

**SO** Establish IV while enroute, run wide open to max 2 liters; additional fluids per BH order  
Monitor ECG; treat dysrhythmias per separate protocols

**NOTE:** Consider **SO** - Ondansetron 4mg ODT/IV/IM for nausea and vomiting related to prolonged off-road transport

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: Rev. 4/16/12

SUBJECT: **TRAUMA (continued)**

POLICY NUMBER: 9270

<b><u>BLS</u></b>	<b><u>ALS</u></b>
<p><b>HELMETS</b> to include full face motorcycle helmets and football helmets:</p> <p><b><u>Indications for removing helmets in the field:</u></b></p> <ul style="list-style-type: none"><li>Inability to assess and/or reassess airway and breathing</li><li>Inability to adequately manage airway and breathing</li><li>Improperly fitted helmet allowing for excessive movement of head</li><li>Proper spinal immobilization cannot be performed due to helmet</li><li>Cardiac arrest</li></ul> <p>NOTE: When removing football helmet, it may be necessary to remove shoulder pads as well to properly immobilize spine</p>	<p><b><u>PEDIATRIC NOTE:</u></b></p> <ul style="list-style-type: none"><li><b>SO</b> Normal Saline 20 mL/kg initial bolus via Volutrol rapid IV drip; may repeat per BH</li><li><b>BHP</b> Morphine IVP for isolated extremity injury</li><li><b>BHP</b> Needle thoracostomy for chest decompression</li></ul>

APPROVAL:



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OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 6/1/2007 rev.

**SUBJECT: PEDIATRIC DRUG GUIDE**

**POLICY NUMBER: 9300**

DRUG/ROUTE CONCENTRATION	PREMMIE	NEWBORN	3 MO	6 MO	1-2 YR	3-4 YR	5-6 YR	7-8 YR	9-10 YR	11-12 YR	13-14 YR
Length CM Range for age >	0-53 cm	54-58 cm	59-65 cm	66-74 cm	75-86 cm	87-99 cm	100-113 cm	114-132 cm	133-158 cm	159-189 cm	190-205 cm
Weight Average KG/LB >	2kg/4lb	3kg/7lb	5kg/12lb	7kg/15lb	11kg/24lb	15kg/33lb	19kg/42lb	24kg/52lb	31kg/68lb	40kg/88lb	50kg/110lb
normal HR >	120-170	100-170	100-170	100-170	100-170	100-160	75-120	70-110	60-105	60-100	60-100
RR >	40-60	40-60	30-50	30-50	30-40	20-30	20	16	16	16	16
Albuterol, nebulized (2.5 mg/3.0 mL)	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL	3 mL
Atropine, IM/IVP 0.02 mg/kg (0.1 mg/mL)	1 mL	1 mL	1 mL	1 mL	2 mL	3 mL	4 mL	5 mL	6 mL	8 mL	10 mL
Charcoal, PO 1 Gm/kg (6.25 Gm/oz)	0.3 oz	0.5 oz	0.9 oz	1.1 oz	1.8 oz	2.4 oz	3 oz	3.8 oz	5 oz	6.4 oz	8 oz
Dextrose 50%, IV (25 Gm/50 mL)	---	---	---	---	---	15 mL	20 mL	25 mL	30 mL	40 mL	50 mL
Dextrose 25%, IV (12.5 Gm/50 mL)	4 mL	6 mL	10 mL	15 mL	25 mL	---	---	---	---	---	---
Diphenhydramine, IM/IV 0.5 mg/kg (50 mg/mL)	---	---	---	---	0.1 mL	0.2 mL	0.2 mL	0.3 mL	0.3 mL	0.4 mL	0.5 mL
Epinephrine 1:1,000 SC 0.01 mg/kg (1 mg/mL)	0.05 mL	0.05 mL	0.05 mL	0.05 mL	0.1 mL	0.1 mL	0.2 mL	0.2 mL	0.3 mL	0.3 mL	0.3 mL
Epinephrine 1:10,000 IV 0.01 mg/kg (1 mg/10 mL)	0.2 mL	0.3 mL	0.6 mL	0.8 mL	1.0 mL	1.5 mL	2.0 mL	2.5 mL	3.0 mL	4.0 mL	5.0 mL
Glucagon, IM 0.05 mg/kg (1 mg/mL)	0.5 mL	0.5 mL	0.5 mL	0.5 mL	1 mL	1 mL	1 mL	1 mL	1 mL	1 mL	1 mL
Lidocaine, IV 1 mg/kg (20 mg/mL)	0.1 mL	0.15 mL	0.25 mL	0.35 mL	0.5 mL	0.75 mL	1.0 mL	1.25 mL	1.5 mL	2.0 mL	2.5 mL
Midazolam, IV 0.1 mg/kg (1 mg/mL)	0.2 mL	0.3 mL	0.5 mL	0.7 mL	1.0 mL	1.5 mL	2.0 mL	2.5 mL	3.0 mL	4.0 mL	5.0 mL
Midazolam, IM 0.2 mg/kg (1 mg/mL) max 1-2 mL inc.	0.4 mL	0.6 mL	1.0 mL	1.5 mL	2.0 mL	3.0 mL	4.0 mL	5.0 mL	6.0 mL	8.0 mL	10 mL

OPERATIONS: BLS/ALS TREATMENT PROTOCOLS

DATE: 6/1/2007 rev.

**SUBJECT: PEDIATRIC DRUG GUIDE**

**POLICY NUMBER: 9300**

DRUG/ROUTE CONCENTRATION	PREMMIE	NEWBORN	3 MO	6 MO	1-2 YR	3-4 YR	5-6 YR	7-8 YR	9-10 YR	11-12 YR	13-14 YR
Length CM Range for age >	0-53 cm	54-58 cm	59-65 cm	66-74 cm	75-86 cm	87-99 cm	100-113 cm	114-132 cm	133-158 cm	159-189 cm	190-205 cm
Weight Average KG/LB >	2kg/4lb	3kg/7lb	5kg/12lb	7kg/15lb	11kg/24lb	15kg/33lb	19kg/42lb	24kg/52lb	31kg/68lb	40kg/88lb	50kg/110lb
normal HR >	120-170	100-170	100-170	100-170	100-170	100-160	75-120	70-110	60-105	60-100	60-100
RR >	40-60	40-60	30-50	30-50	30-40	20-30	20	16	16	16	16
Morphine, IM/IV 0.1 mg/kg (10 mg/mL) max .2 mL inc.	---	---	---	---	0.1 mL	0.1 mL	0.2 mL	0.2 mL	0.3 mL	0.4 mL	0.5 mL
Naloxone, IM/IV 0.1 mg/kg (1 mg/mL)	0.2 mL	0.3 mL	0.5 mL	0.7 mL	1 mL	1.5 mL	2 mL	2 mL	2 mL	2 mL	2 mL

Biphasic or Sych. Cardioversion

Initial shock at 2 J/kg >	5 J	7 J	10 J	15 J	20 J	30 J	40 J	50 J	60 J	80 J	100J
subsequent shocks at 4 J/kg >	10 J	15 J	20 J	30 J	40 J	60 J	80 J	100J	120 J	160 J	200 J

Monophasic

Initial shock at 2 J/kg >	5 J	7 J	10 J	15 J	20 J	30 J	40 J	50 J	60 J	80 J	100J
subsequent shocks at 4 J/kg >	10 J	15 J	20 J	30 J	40 J	60 J	80 J	100J	120 J	160 J	200 J

APPROVAL:



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