Field Treatment Book
Selected MCEMSA Policies

November 17, 2025

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ALS General Guidelines

Adult Treatment Guidelines

Pediatric Treatment Guidelines

Miscellaneous Policies

MCEMSA Field Treatment Book

Adult Treatment Guidelines

POLICY: 554.00
TITLE: General Protocols

EFFECTIVE: 2/1/2025
REVIEW: 2/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PROTOCOLS

I. AUTHORITY
Health & Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE
To serve as the treatment standard for Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs), and Paramedics in treating patients.

III. PROTOCOL

A. These are the treatment protocol standards for the Mountain Counties Emergency Medical Services Region. This document is divided into three major sections:

1. **General Procedures**
   a. Contains individual treatment procedures that can be found throughout MCEMSA protocols.
   b. **ALS** or Advanced Life Support procedures are procedures performed by a MCEMSA accredited Paramedic.
   c. **BLS** or Basic Life Support procedures are procedures performed by an individual providing care for an MCEMSA approved or recognized provider. We do not certify all individuals providing BLS care in our system.

2. **Treatment Protocols**
   a. **Adult** – Patient's age 15 and older
   b. **Pediatric** –Patient's age 14 and younger

3. **Field Specific Policies**
   a. Medication Index
   b. Procedure Index

MEDICAL CONTROL

I. STANDING ORDERS

A. **Standing Orders** are "treatments a licensed and accredited ALS, and/or certified EMT, and/or certified EMR provider can perform without Base Hospital permission".

B. The following are considered **Standing Orders:**

1. All BLS skills and treatment

2. All ALS skills and treatment **EXCEPT** those limited to **Base Physician Orders**

II. BASE PHYSICIAN ORDERS

A. **Base Physician Orders** are treatment procedures that require a direct order from a Base Hospital Physician. The Base Hospital Physician may order any medications or procedures within the local paramedic scope of practice regardless of the treatment protocol. Verbal orders **MUST** be signed by the Base Physician and maintained in the patient medical record. The paramedic must call the base hospital to which they are transporting the patient. The physician's name must be documented in the Pre-Hospital Patient Care Report.

B. An MICN may **RELAY** a verbal "**Base Physician Order**" from the Base Physician in accordance with any of the approved protocols.

III. ALS WITHOUT BASE HOSPITAL CONTACT FORM

A. If a paramedic cannot make Base Hospital Physician Contact, a paramedic can perform treatments listed under **"Base Physician Order".**

B. Documentation on an **"ALS without Base Hospital Contact Form"** must be completed listing any **"Base Physician Order"** treatments performed. The form must be forwarded to the Mountain Counties EMS Agency within 24 hours of the call's occurrence.

VASCULAR ACCESS

A. Pre-Vascular Access Device (PVAD) – (e.g., arteriovenous shunt, tunneled catheters, and Peripherally Inserted Central Catheters (PICC lines)

1. A PVAD should only be used when a **life-threatening condition requires immediate fluid therapy or IV medications and no other access is accessible.**

2. A Base Hospital MICN or Physician should be consulted if the paramedic is unfamiliar with the type of indwelling catheter.

3. Aseptic technique **MUST** be followed.

4. Attempt to withdraw and discard 5 mL of blood from the device prior to infusion. If **unable** to withdraw, do not proceed with the infusion.

5. Use a Huber-type non-coring needle, whenever possible.

6. Follow manufacturer recommended settings and insertion techniques.

TRANSPORT

I. TRANSPORT

A. Crew judgement based on clinical presentation, weather and roadway conditions

II. Patient Destination:

A. All patients who wish to be transported by ambulance to the hospital should be transported.

B. Patients should be transported to the closest hospital appropriate for their medical needs within a reasonable transport time or as specified in the patient treatment protocols.

C. During a declared MCI– patient destination will be at the direction of the Medical Group Supervisor, in conjunction with the Disaster Control Facility (DCF) based on location and availability of services.

D. Patients, not meeting specialty care criteria, i.e. Stroke, STEMI and/or Trauma will be transported to the hospital of their preference within a reasonable request. It is recommended the crew consult with their on-duty supervisor to confirm transports to facilities outside of the county that are not a routine destination.

E. If there are multiple patients in one ambulance, all patients will be transported to the same receiving facility.

RESPIRATORY GUIDELINES

A. Endotracheal Intubation:

1. Oral endotracheal intubation, stomal endotracheal intubation, and placement of a King-Tube (perilaryngeal airway) or I-Gel (Supraglottic airway) as a rescue airway are standing orders in patients who require advanced airway management. The I-Gel rescue airway, an approved Supraglottic airway device, may be inserted in any patient that fits on to a length-based tape designed to estimate weight and/or medication doses (ie: Broselow) only if unable to adequately ventilate with BVM using the jaw thrust method and BLS airway adjuncts. **Endotracheal intubation shall not be performed on any patient that fits on a length-based tape designed to estimate weight and/or medication doses (ie: Broselow).**

2. Paramedics must not attempt any form of tracheal intubation more than three (3) times per patient. An attempt to intubate is defined as placement of the laryngoscope blade in a patient's mouth **with the intent to intubate**. A Bougie shall be used as an adjunct to intubation at any time during the intubation procedure. If a total of three attempts are unsuccessful, paramedics will insert an alternative airway (in adults) or use BLS airway techniques (in adults or pediatrics).

3. When appropriate, pediatric patients shall have the appropriate sized I-Gel (Supraglottic airway) inserted following the manufacturers procedure for placing and using the device.

4. Correct tube placement must be confirmed and documented by at least three of the following indicators: Visualize ET tube passing through vocal cords, ET tube fogs with ventilations, equal breath sounds, absent epigastric sounds, and chest rise and fall. All patients must be assessed immediately after intubation with an end-tidal CO_2 detector, colorimetric or continuous waveform. The number of centimeters at which the tube is secured, confirmatory indicators, and color change or waveform reading must be documented on the Prehospital Care Report. All intubated patients must be continuously assessed using ETCO2 waveform capnography. Any significant movement, emesis or change in clinical condition should be reassessed using waveform capnography and physical examination. If, at any time, capnography indicates that the tube is not in communication with the trachea, the airway must be immediately removed and re-intubation attempted.

5. All ET tubes and rescue airways should be secured using a commercially available device designed to secure ET tubes. Rescue airways should be secured according to manufacturer recommendations.

MECHANICAL CHEST COMPRESSION DEVICE

I. If available, the approved mechanical chest compression device shall be deployed by an EMT level or higher on any patient that meets the indications listed in this policy when the device is available, and the approved training has been completed.

II. **Indications**:

A. Patients 15 years of age or older

B. Medical and/or Traumatic cardiac arrest where manual CPR is indicated

III. **Contraindications:**

A. Patients 14 years of age or younger

B. If unable to correctly position the device due to size of the patient's chest.

IV. **Procedure:**

A. Initiate resuscitative measures according to "Cardiac Arrest Algorithms" 554.11

B. DO NOT attempt placement of the mechanical chest compression device until the third (3^{rd}) cycle of manual compressions and at least three (3) rescuers are available to limit interruptions in chest compressions. DO NOT delay any interventions such as: Defibrillation, Intravenous or Intraosseous access, and medication administration for placement of the mechanical chest compression device.

C. Limit interruption in chest compressions to 10 seconds or less

D. Remove all clothing from the front and back of patient's torso.

E. Follow all manufacturer recommendations for application and use of the mechanical compression device.

F. Defibrillation can be performed with the mechanical chest compression device in place. There is no need to stop the device for the purpose of defibrillation.

G. In the event of disruption or malfunction of the mechanical chest compression device, immediately revert to manual CPR.

H. If a cardiac arrest patient is transported, the mechanical chest compression device shall remain in place to continue or resume CPR as necessary.

I. Personnel that deploy a mechanical chest compression device shall ensure

that a person trained and qualified to use the device accompanies the patient to the hospital, even if they are not the primary patient caregiver.

J. All mechanical compression devices will be set at a rate of 100-120 compressions per minute. Changes will only be made with approval of the MCEMSA Medical Director.

K. Any device purchased prior to September 1, 2018, follow manufacturer recommendations for operation.

V. **Mechanical Chest Compression Device Maintenance:**

A. The periodic preventative maintenance of all devices shall meet or exceed the criteria recommended by the manufacturer.

B. Providers shall immediately remove from service any device suspected of malfunctioning. Any malfunctioning device shall not be placed back into service until properly serviced or repaired by the manufacturer's authorized service program.

C. Device maintenance records shall be subject to review and inspected by MCEMSA upon request.

VI. **Quality Improvement:**

A. Documentation and data related to the use of the mechanical chest compression device shall be provided to MCEMSA.

B. All patient contacts involving the use of the mechanical chest compression device shall undergo chart review by the provider QI personnel. Chart review shall include evaluation for appropriate clinical use and adherence to MCEMSA policies and treatment protocols.

C. Any concerns or issues involving the use of the mechanical chest compression device shall be reported to MCEMSA as soon as possible.

POLICY: 554.04
TITLE: Symptomatic Bradycardia

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SYMPTOMATIC BRADYCARDIA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Bradycardia is characterized by a heart rate < 60. It may be secondary to sinus node disease, increased parasympathetic tone or drug effects (e.g., digitalis, propranolol or Verapamil). The rhythm is regular or slightly irregular with the heart rate < 60 beats per minute.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
PULSE OXIMETRY: apply and monitor.	X	X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
12 LEAD ECG				X	
ATROPINE: 1 mg IV/IO push. Repeat every 3-5 minutes for a maximum total dose of 3 mg.				X	
TRANSCUTANEOUS CARDIAC PACING: If patient remains hemodynamically unstable with serious signs & symptoms, DO NOT delay TCP waiting for vascular access or for atropine to take effect. Place pacing pads on the Anterior/ Posterior thorax, if possible. Start current level at 10 milliamps, increase current until electrical capture noted. Start at a rate of 60/minute and increase rate as needed. Check pulses to confirm mechanical capture.				X	

	F	E	O	P	D
PAIN MANAGEMENT: • **FENTANYL**: 1 – 2 mcg/kg IV/IO/IM/IN. If initial dose given IV/IO/IN, may repeat in 5 minutes, or if initial dose given IM may repeat in 10 minutes. Repeat doses at 0.5 mcg/kg. Maximum total 3 mcg/kg. • **MIDAZOLAM**: 0.5 – 1 mg increments titrated to patient's pain or spasm up to 5 mg IV/IO/IN. If no IV access available, 2 – 10 mg IM, 10 mg maximum				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5-10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	

CONSIDER CAUSES

- Hypoxia - provide ventilation. Check for reversible cause of hypoventilation.
- 554,62 HYPOTHERMIA
- 554.51 POISONING
- 554.54 OVERDOSE

POLICY: 554.05
TITLE: Tachycardia with Pulses

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES: 554.05 Ventricular Tachycardia with Pulses
554.06 Supraventricular Tachycardia
554.07 Wide Complex Tachycardia of Uncertain Type

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TACHYCARDIA with PULSES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor		X	X	X	
CAPNOGRAPHY: apply and monitor				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
12 LEAD ECG				X	
UNSTABLE: hypotension, altered mental status, signs of shock, ischemic chest discomfort, acute heart failure					
PAIN MANAGEMENT: If the patient's clinical condition is critical, do not delay cardioversion and cardiovert without sedation. • **MIDAZOLAM:** 0.5 – 1 mg increments titrated to patient's pain or spasm up to 5 mg IV/IO/IN. If no IV access available, 2 – 10 mg IM, 10 mg maximum • **FENTANYL:** 1-2 mcg/kg IV/IO/IM/IN. Maximum total 3 mcg/kg.				X	
CARDIOVERT: Synchronized at 100 to 200 J. If unsuccessful at less than 200 J, increase by 50 J to maximum 200 J on repeat cardioversion.				X	
MAGNESIUM SULFATE: For Torsade de Pointes 2 gm, diluted with NS to a volume of 10 mL over 5 minutes IV/IO.				X	

	F	E	O	P	D
STABLE: QRS < 0.12 seconds					
VAGAL MANEUVER: have patient hold their breath and bear down or immerse patient's face in ice-cold water.				X	
ADENOSINE: 6 mg, rapid IV push over 1-3 seconds. If rhythm does not convert, repeat adenosine at 12 mg. Maximum total dose of 18 mg. Follow each medication administration with 5-10 mL normal saline flush.				X	
STABLE: QRS ≥ 0.12 seconds					
ADENOSINE: if regular and monomorphic administer 6 mg, rapid IV push over 1-3 seconds. If rhythm does not convert, repeat adenosine at 12 mg. Maximum total dose of 18 mg. Follow each medication administration with 5-10 mL normal saline flush.				X	
ANTIARRHYTHMIC: choose one • **AMIODARONE**: 150 mg in 100 mL of NS, infused IV/IO over 10 minutes. May repeat as needed up to a max of 450 mg. • **LIDOCAINE:** 1.5 mg/kg IV/IO. If rhythm does not convert, administer lidocaine 0.75 mg/kg IV push. Repeat every 5 - 10 minutes until effective or until maximum total of 3 mg/kg. ○ **LIDOCAINE DRIP:** If rhythm converts with lidocaine, start lidocaine IV drip at 2 – 4 mg per minute.				X	
ASSESSMENT: if arrythmia not resolved with medication intervention, consider cardioversion with pain management as above.				X	

POLICY: 554.08
TITLE: Atrial Fibrillation – Atrial Flutter

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ATRIAL FIBRILLATION – ATRIAL FLUTTER

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Atrial Fibrillation: Rhythm is irregularly irregular. Atrial rate 350 to 600 but, as a rule, cannot be counted. Ventricular rate varies between normal and tachycardic. Patient may be on medication such as digoxin, amiodarone, B-blockers, or Ca-channel blockers. Fibrillatory waves may be coarse or fine. QRS complex usually normal. Some patients may alternate between atrial fibrillation and atrial flutter.

Atrial Flutter: Atrial rhythm regular. Ventricular rhythm may be regular or irregular if variable block is present. Ventricular rate 140 to 160 but may be slower if the patient is on medication such as digoxin, amiodarone, B-blockers, or Ca-channel blockers. QRS complex usually normal and may follow every second, third or fourth flutter wave. Some patients may alternatebetween atrial fibrillation and atrial flutter.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: If pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
***12 LEAD ECG**				X	

UNSTABLE	F	E	O	P	D
MIDAZOLAM: 2 mg slow IV/IO/IM/IN. If the patient's clinical condition is critical, do not delay and cardiovert without sedation.				X	
CARDIOVERT: synchronized at 50 J. If unsuccessful, increase by 50 J to maximum 200 J on repeat cardioversion.				X	

STABLE	F	E	O	P	D
CALCIUM CHLORIDE: 500 mg slow IV/IO push. Use with caution in patients taking digoxin.				X	
VERAPAMIL: 2.5 mg slow IV/IO push over 2 minutes. May repeat every 5 minutes. Hold for SBP < 100.				X	

*** If 12 Lead ECG interprets an S-T Elevation Myocardial Infarction (STEMI), refer to Policy 530.00 STEMI TRIAGE AND DESTINATION.**

POLICY: 554.09
TITLE: Suspected Cardiac Chest Discomfort

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES: 554.09 Coronary Ischemic Chest Discomfort

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SUSPECTED CARDIAC CHEST DISCOMFORT

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Chest discomfort due to a heart attack or another heart problem may feel like: Pressure, fullness, burning or tightness in the chest. Crushing or searing pain that spreads to the back, neck, jaw, shoulders, and one or both arms. Consider any chest discomfort without clear traumatic cause.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
OXYGEN: If pulse oximetry < 94% or signs of respiratory distress, or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
ASPIRIN: 324 mg PO. Aspirin is to be administered even if chest pain has resolved, unless otherwise contraindicated.		X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
****12 LEAD ECG**				X	
***NITROGLYCERIN**: 0.4 mg sublingual to relieve pain. May repeat every 5 minutes with a maximum of 3 doses in 20 minutes. Hold for SBP < 100.				X	
PAIN MANAGEMENT: choose morphine **OR** fentanyl from 554.44 PAIN MANAGEMENT.				X	
CAPNOGRAPHY: apply and monitor if narcotics administered.				X	
LIDOCAINE: 1.5 mg/kg IV/IO push for the treatment of escalating ventricular ectopy. Repeat in 5 minutes at 0.75 mg/kg if ectopy returns.				X	

**** If 12 Lead EKG interprets an S-T Elevation MI (STEMI), refer to Policy 530.00 STEMI TRIAGE AND DESTINATION.**

***Nitroglycerin shall not be given to pts who have taken PDE-5 inhibitors (sildenafil, Cialis, Viagra or similar) within the last 48 hours; instead, start with morphine or fentanyl.**

POLICY: 554.10
TITLE: Acute Pulmonary Edema

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES: 554.10 Congestive Heart Failure

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ACUTE PULMONARY EDEMA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
History may include: elderly patient, heart problems (hypertension, congestive heart failure), dyspnea worse when lying down (orthopnea), symptoms of acute MI, takes "water pills," sudden weight gain, cough with pink frothy sputum.

Medications may include: digoxin, lanoxin, digitoxin, chlorothiazide, furosemide, hydrochlorothiazide, bumetanide.

Physical findings may include: rales, distended neck veins, pedal or presacral edema.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
POSITION: sitting (as tolerated).					
VASCULAR ACCESS: IV/IO, rate as indicated.				X	

	F	E	O	P	D
***NITROGLYCERIN**: • 0.4 mg sublingual, (1 tablet/spray) for systolic BP 100-120 mmHg. • 0.8 mg sublingual, (2 tablets/sprays) for systolic BP 120-200 mmHg. • 1.2 mg sublingual, (3 tablets/sprays) for systolic BP > 200 mmHg. May repeat every 3-5 minutes, maximum of 9 tablets/sprays. Hold when respiratory distress is alleviated, severe headache develops, or systolic BP drops below 100mmHg. **AND** ***NITROGLYCERIN PASTE** 1" (If systolic BP < 100 mmHg, NTG should be withheld or discontinued by wiping off with a clean towel).				X	
BASE CONTACT: for additional NTG orders.					X
CPAP or POSITIVE PRESSURE VENTILATION: as indicated.				X	
MORPHINE: 2 – 5 mg increments IV/IO. May repeat as needed not to exceed 20 mg per 30 minutes. Hold for systolic BP < 90.				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5-10 mcg) IVP every 1-5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	

***Nitroglycerin shall not be given to pts who have taken PDE-5 inhibitors (sildenafil, Cialis, Viagra or similar) within the last 48 hours; instead, start with Morphine**

POLICY: 554.11
TITLE: Cardiac Arrest – Non-Traumatic

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CARDIAC ARREST – NON-TRAUMATIC

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
HP-CPR: including AED. When available and appropriate, use mechanical compression device or switch CPR providers every 2 minutes. Avoid interruption.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts. Ventilate with 100% oxygen.	X	X	X	X	
OXYGEN: ventilate with 100% oxygen.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
ADVANCED AIRWAY: consider SGA.			X	X	
CAPNOGRAPHY: apply and monitor.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
EPINEPHRINE: 1 mg (10 mL) 1:10,000 (0.1 mg/mL) IV/IO push. Repeat every 3 – 5 minutes.				X	
VENTRICULAR FIBRILLATION - PULSELESS VENTRICULAR TACHYCARDIA					
DEFIBRILLATE: 200 J (Biphasic) (AED only for F and EMT). Reanalyze rhythm every 2 minutes.	X	X	X	X	
AMIODARONE: 300 mg IV/IO over 1–2 minutes, followed by 20 mL NS. Repeat once in 5 minutes at 150 mg IV/IO followed by 20 mL NS.				X	
LIDOCAINE: **Consider if V-fib/V-Tach refractory to amiodarone**. 1.5 mg/kg IV/IO push. Repeat at 0.75 mg/kg every 5-10 minutes, up to a maximum of 3 mg/kg total.				X	
MAGNESIUM SULFATE: For Torsade de Pointes 2 gm, diluted with NS to a volume of 10 mL over 5 minutes IV/IO.				X	

	F	E	O	P	D
PULSELESS ELECTRICAL ACTIVITY/ASYSTOLE CONSIDER					
SODIUM BICARBONATE: 1 mEq/kg IV/IO for known or suspected hyperkalemia (renal patients) or tricyclic antidepressant overdose.				X	
CALCIUM CHLORIDE: 1000 mg (10 mL of 10% sol.) IV/IO for known or suspected hyperkalemia (renal patients). **Note: Use with caution in patients on digoxin.**				X	
CONSIDER					
TEST FOR GLUCOSE		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10-minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150mL.				X	
GLUCAGON: If no IV/IO, give 1 mg IM if blood glucose < 70 mg/dL or suspicion of beta blocker or calcium channel blocker overdose. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat 1 mg IM.					
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.4 – 2 mg IV/IO/IM (if opioid use is suspected).				X	
IF NO ROSC					
****TERMINATION of RESUSCITATION:** 1: If EMS did not witness cardiac arrest and 2. No shockable rhythm and 3. No ROSC after 20 minutes of BLS and/or ALS resuscitation	X	X	X	X	

IF ROSC	F	E	O	P	D
***12 LEAD ECG**				X	
ADVANCED AIRWAY: if ROSC achieved and no SGA in place, consider ETI.				X	
PULSE OXIMTRY: target pulse oximetry to ≥ 92-98%.				X	
CAPNOGRAPHY: ventilation should start at 10/minute and titrate target ETCO2 of 35 – 45 mmHg.				X	
ANTIARRYTHMIC: if Amiodarone or Lidocaine used to achieve ROSC, consider amiodarone or lidocaine drip for persistent dysrhythmia. • **AMIODARONE**: 1 mg/minute • **LIDOCAINE**: 1 – 4 mg/minute				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	

****Refer to Policy #570.20, DETERMINATION OF DEATH IN THE PREHOSPITAL SETTING**
Reference: 10/17/2022 EMS Termination Of Resuscitation And Pronouncement of Death - StatPearls - NCBI Bookshelf (nih.gov) https://www.ncbi.nlm.nih.gov/books/NBK541113/

***If 12 Lead ECG interprets an S-T Elevation Myocardial Infarction (STEMI), refer to Policy 530.00 STEMI TRIAGE AND DESTINATION.**

CONSIDER CAUSES
• Hypovolemia - volume infusion, 2 liters followed by 250 mL boluses as indicated.

• Cardiac tamponade - volume infusion, 2 liters followed by 250 mL boluses as indicated.
• Hypoxia - provide ventilation. Check for reversible cause of hypoventilation.
• Tension pneumothorax - refer to 554.23 TENSION PNEUMOTHORAX..
• Hypothermia - refer to 554.62 HYPOTHERMIA.
• Drug Overdose - refer to 554.51 POISONING.

POLICY: 554.21
TITLE: Airway Obstruction - Stridor

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

AIRWAY OBSTRUCTION - STRIDOR

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: if indicated.				X	
SEVERE OBSTRUCTION - UNABLE TO COUGH OR SPEAK CONSIDER CAUSE - FOREIGN BODY OBSTRUCTION	F	E	O	P	D
ABDOMINAL THRUSTS	X	X	X	X	
REMOVE FOREIGN BODY	X	X	X	X	
LARYNGOSCOPY, SUCTION, &/OR MANUAL REMOVAL with Magill Forceps.				X	
REASSESS: repeat basic airway maneuvers until obstruction is cleared or the patient becomes unconscious.	X	X	X	X	
SECURE AIRWAY: consider ETI or SGA. If object not visible or lodged below the cords and patient in respiratory failure.				X	
NEEDLE CRICOTHYROTOMY: if unable to intubate, Quicktrach device. Ventilate with high flow oxygen.				X	

	F	E	O	P	D
CONSIDER CAUSE – CROUP/EPIGLOTTIS					
POSITION OF COMFORT: minimize stress to patient.	X	X	X	X	
NEBULIZED SALINE: with high flow oxygen.				X	
EPINEPHRINE: 1:1,000 (1 mg/mL) 2.5 mg nebulized .					X
AVOID VISUALIZATION OF THROAT: unless ETI required.				X	
NEEDLE CRICOTHYROTOMY: Quicktrach device. Ventilate with high flow oxygen.				X	

POLICY: 554.23
TITLE: Tension Pneumothorax

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TENSION PNEUMOTHORAX

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Physical signs may include: decreased breath sounds, increased resonance on the side of collapsed lung, tracheal deviation, asymmetrical chest motion and crepitus.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts. Ventilate with 100% oxygen.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
NEEDLE THORACOSTOMY: on affected side(s) between 2nd & 3rd intercostal space midclavicular line, OR between 4th & 5th intercostal space midaxillary line. Place catheter just above the rib to avoid the intercostal artery. Place approved chest seal over or one-way valve on the catheter. Repeat if suspected catheter occlusion.				X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
ASSESSMENT: continue to monitor for signs of recurrence of tension pneumothorax.	X	X	X	X	

POLICY: 554.24
TITLE: Chronic Obstructive Pulmonary Disease – Asthma - Bronchospasm

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE – ASTHMA - BRONCHOSPASM

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
COPD: History may include: emphysema, bronchitis, heavy smoking, recent upper respiratory infection, chronic dyspnea, inhalers.

Physical findings may include: increased anteroposterior diameter of the chest, pursed-lip breathing, wheezing, rhonchi, prolonged expiratory phase of respiration, and use of accessory muscles to breathe.

ASTHMA: History may include: acute episodic dyspnea, allergies, upper respiratory infection or flu may have preceded attack.

Physical findings may include: wheezing, hyperresonance, and/or if bronchospasm severe, diminished breath sounds may be diminished.

Medications may include: inhalers, pseudoephedrine, theophylline, Actifed, oral and/or inhaled steroids.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
MAY ASSIST PATIENT ADMINISTER THEIR OWN INHALER		X	X	X	

	F	E	O	P	D
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists (consider availability or need to reduce aerosol-generating procedure to decide which). • **ALBUTEROL:** 2-10 inhalations via metered dose inhaler or 2.5 mg via nebulizer. If patient intubated, administer dose through aerosol holding chamber. • **LEVALBUTEROL**: 1.25 mg via nebulizer.				X	
IPRATROPIUM: 500 mcg via nebulizer. If patient intubated, administer dose through aerosol holding chamber.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
MAGNESIUM SULFATE: 2 gm in 100 mL of NS, infused IV/IO over 20 minutes.				X	
***EPINEPHRINE:** 0.3 mg of 1:1000 (1 mg/mL) IM via auto injector.		X	X	X	
***EPINEPHRINE:** 0.3 mg of 1:1000 (1 mg/mL) IM.			X	X	
CPAP		X	X	X	

*** Use caution in the presence of coronary artery disease or history of hypertension.**

POLICY: 554.25
TITLE: Acute Cerebrovascular Accident

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ACUTE CEREBROVASCULAR ACCIDENT

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Characterized by weakness or paralysis on one side of the body/face, slurred speech, aphasia, difficulty with balance, inability to understand, difficulty in naming objects, confusion, difficulty swallowing, headache, acute visual disturbances (double vision, blindness, paralysis of extra-ocular muscles).

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor	X	X	X	X	
CAPNOGRAPHY: apply and monitor				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
***VAN SCALE**				X	
STROKE ALERT: if positive VAN, notify receiving hospital				X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
TEST FOR GLUCOSE		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	

*If VAN positive, refer to Policy 522.20 STROKE TRIAGE, TREATMENT AND DESTINATION..

Vision, Aphasia, Neglect (VAN) Scale

	Normal	Mild	Moderate	Severe
How weak is the Patient? Raise both arms.	No signs of weakness	Minor Drift	Severe drift- touches or nearly touches the ground	Flaccid or no antigravity

Visual Disturbances	Aphasia	Neglect
Field cut (which side) (4 quadrants)	Expressive (inability to speak or paraphasic errors); do not count slurred words (repeat & name 2 objects)	Forced gaze or inability to track to one side.
Double Vision (ask pt. to look to right then left; evaluate for asymmetric gaze)	Receptive (not understanding or following commands) i.e., close eyes, make a fist.	Unable to feel both sides at the same time, or unable to identify own arm.
Blind – New Onset	Mixed	Ignoring one side.
None	None	None

*Patient must have weakness and one or more of the V, A, N to be VAN Positive.

POLICY: 554.31
TITLE: Altered Level of Consciousness

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALTERED LEVEL OF CONSCIOUSNESS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Characterized by a Glasgow coma score of < 15 or change from baseline mental status, confusion, and unresponsiveness.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
12 LEAD EKG: consider.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.	X	X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 1 mg IM if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat 1 mg IM.				X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 10 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	

	F	E	O	P	D
NALOXONE: 0.4 - 2 mg IV/IO/IM for respiratory depression. If opioid overdose is suspected, may repeat in 0.4 - 2 mg increments to a total of 12 mg.				X	

RULE OUT

A- Alcohol
E- Epilepsy
I- Infection
O- Overdose/Underdose
U- Uremia

T- Trauma/Toxins
I- Insulin
P- Psychosis
S- Stroke

POLICY: 554.33
TITLE: Status Seizures

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

STATUS SEIZURES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
An actively seizing patient who has been seizing for more than ten minutes or an actively seizing patient with recurrent seizures, with no return to baseline mental status between seizures.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
POSITION: place on left side if pregnant. Consider PREECLAMPSIA/ECLAMPSIA A71 if no history of seizure disorder.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
MIDAZOLAM: Do not delay for IV/IO access. • IM/IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO – 1-2 mg every 2 minutes until seizure stops or max 10 mg.				X	
TEST FOR GLUCOSE		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	

POLICY: 554.34
TITLE: Behavioral Emergency

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

BEHAVIORAL EMERGENCY

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
The vast majority of patients are not violent, requiring only supportive care & transport. Responder & patient safety are paramount, especially when treating an aggressive or violent patient. **Restraints are to be used only to prevent injury & assure safety of the patient and/or responders.** EMS personnel shall make every effort to preserve the patient's health, safety, dignity, rights, & well-being.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SCENE SAFETY	X	X	X	X	
ASSESSMENT	X	X	X	X	
VERBAL DE-ESCALATION: if possible. Use non-judgmental terminology, speak in a calm voice, and avoid direct eye contact.	X	X	X	X	
***APPROVED PHYSICAL RESTRAINTS:** assure restraints do not compromise respirations, circulation, and neurological function. **Reassess & document distal neurovascular status every 15 minutes.**	X	X	X	X	
***CHEMICAL RESTRAINT:** 2 – 5 mg midazolam IV/IO/IM/IN. May be done prior to or in conjunction with approved physical restraints. May repeat every 5 – 10 minutes if systolic BP is ≥ 100 and respiratory rate is ≥ 12.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if chemical restraint administered.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
OLAZAPINE: 10 mg ODT SL. For use with a cooperative, anxious adult patient with a primarily behavioral health presentation and a history of psychiatric disorder				X	

*** 580.00 USE OF PATIENT RESTRAINTS**

The following forms of restraint shall **NOT** be used by prehospital personnel:

1. Hard plastic ties or any restraint device requiring a key to remove with the exception of restraints applied by law enforcement.
2. Sandwiching patient between backboards, scoop-stretchers, or flat.
3. Restraining both a patient's hands and feet behind the patient, i.e., hog-tying.
4. Methods or other materials applied in a manner that could cause respiratory, vascular, or neurological compromise, including prone restraints.

Restraints applied by law enforcement require the officer's continued presence to ensure patient and prehospital personnel safety. The officer shall accompany the patient in the ambulance or follow the ambulance.

POLICY: 554.40
TITLE: Sepsis

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SEPSIS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Sepsis is a potentially lethal medical condition that is characterized by a whole-body inflammatory state called Systemic Inflammatory Response Syndrome (SIRS). The immune system develops this inflammatory response to microbes in the blood, urine, lungs, skin or other tissues. The syndrome can include fever, tachycardia, tachypnea and hypotension.

Sepsis is more common in the elderly, newborns, diabetics, and persons with a compromised immune system. Other risk factors include cancer, renal disease, alcohol/drug abuse, malnutrition, hypothermia, recent surgery or invasive procedure.

Patient should be presumed to be septic if the patient meets two or more of the following criteria with no other identifiable cause:

1. Temperature > 100.4° or < 96°
2. Heart rate >90
3. Respiratory rate > 20

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
SEPSIS ALERT: if sepsis criteria met.		X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: administer 250 mL NS boluses up to a total of 30 mL/kg. Reassess the patient after each bolus administration. Use caution when administering large amounts of fluid to patients with CHF and/or renal failure.				X	
BASE CONTACT: for additional fluid orders.					X

	F	E	O	P	D
ACETAMINOPHEN: 15 mg/kg, oral suspension or IV infusion. IV infusion administer over 15 minutes. Max dose 1000 mg. No repeat dose.				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	

POLICY: 554.41
TITLE: Non-Traumatic Shock

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NON-TRAUMATIC SHOCK

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
History may include: GI bleeding, vomiting, diarrhea, allergic reaction, septicemia, antihypertensive medication overdose.

Physical signs may include: collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse, pale/cold/clammy/mottled skin, rapid respirations, and anxiety. Signs of compensation may be absent in the elderly or patients taking beta-blocker or alpha-blocker medications.

NOTE: a decreased blood pressure is a late sign of shock.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BODY TEMPERATURE	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of hypoperfusion or respiratory distress	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
12-LEAD ECG				X	
VASCULAR ACCESS: IV/IO, 2 large bore.				X	
FLUID BOLUS: If patient has a systolic BP < 90, administer 250 mL NS bolus as indicated. Reassess after each bolus. Maximum fluid 2 liters.				X	
POSITION: Trendelenburg position as tolerated. Place on left side if pregnant.	X	X	X	X	

	F	E	O	P	D
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5-10 mcg) IVP every 1-5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 ADULT MEDICATION CHARTS.				X	
BASE CONTACT: if blood pressure remains hypotensive.					X

POLICY: 554.42
TITLE: Glycemic Emergencies

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GLYCEMIC EMERGENCIES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Blood sugar testing is the only accurate method to determine if a patient is hypoglycemic or hyperglycemic.

Hypoglycemia: Blood glucose < 70 mg/dL. Characterized by: ALOC, seizures, combativeness, psychosis, disorientation, diaphoresis, shaking.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor		X	X	X	
CAPNOGRAPHY: apply and monitor				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
HYPOGLYCEMIA Blood glucose < 70 mg/dL	F	E	O	P	D
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex	X	X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 1 mg IM if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat 1 mg IM.				X	

HYPERGLYCEMIA Blood glucose > 300 mg/dL	F	E	O	P	D
VASCULAR ACCESS: IV				X	
FLUID BOLUS: administer 250 mL fluid bolus of NS, up to a total of 2 liters. Reassess after each bolus. HYDRATE WITH CAUTION in patients with chronic renal failure, CHF, and hypertension.				X	

POLICY: 554.43
TITLE: Allergic Reaction

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALLERGIC REACTION

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
REMOVE ALLERGEN: (i.e., bee stinger) & apply ice to site if indicated.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
MILD or MODERATE REACTION (Rash, Swelling, Wheezing)	F	E	O	P	D
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists (consider availability or need to reduce aerosol-generating procedure to decide which). If patient intubated, administer inhaled medication through aerosol holding chamber. Repeat as indicated. • **ALBUTEROL:** 2-10 inhalations via metered dose inhaler or 2.5 mg via nebulizer. If patient intubated, administer dose through aerosol holding chamber. • **LEVALBUTEROL**: 1.25 mg via nebulizer.				X	
DIPHENHYDRAMINE: 25-50 mg IV/IO push or IM if IV/IO access not promptly available.				X	

	F	E	O	P	D
***EPINEPHRINE:** 0.3 mg of 1:1000 (1 mg/mL) IM via auto injector.		X	X	X	
***EPINEPHRINE:** 0.3 mg IM of 1:1000 (1 mg/mL). May repeat once in 3-5 minutes.			X	X	
SEVERE REACTION (Hypotension, severe respiratory depression, oral swelling, altered mental status, chest tightness)	F	E	O	P	D
VASCULAR ACCESS: IV/IO, 2 large bore. Administer 250 mL fluid boluses as indicated. Reassess after each bolus.				X	
DIPHENHYDRAMINE: 25-50 mg. IV/IO slow push or IM if IV/IO access not promptly available.				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5-10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 ADULT MEDICATION CHARTS.				X	
NEEDLE CRICOTHYROTOMY: For airway obstruction and inability to ventilate by other means (BVM, SGA, ETT) use Quicktrach device. Ventilate with high flow oxygen				X	

*** Use caution in the presence of coronary artery disease or history of hypertension.**
NOTE: The order in which medications are administered is discretionary.

POLICY: 554.44
TITLE: Pain Management

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAIN MANAGEMENT

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Pain control can reduce the patient's anxiety and discomfort, therefore making patient care easier. The patient's severity of pain must be properly assessed in order to provide appropriate relief. This protocol is not intended to totally alleviate pain, but to safely decrease the intensity of the pain without causing physiologic compromise, delaying transport to definitive care, or interfering with the patient's diagnostic work up following arrival at the emergency department.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT: including pain scale.	X	X	X	X	
PULSE OXIMETRY: consider if administering sedating medication.		X	X	X	
CAPNOGRAPHY: consider if administering sedating medication.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
PAIN TREATMENT (NON-CARDIAC): consider non-pharmaceutical options: position of comfort, splint, ice, elevate as indicated.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
PHARMACEUTICAL PAIN TREATMENT: Choose most appropriate pharmaceutical intervention below. Non-opioid interventions should be considered first.				X	
ACETAMINOPHEN: 15 mg/kg, oral suspension or IV infusion. IV infusion administer over 15 minutes. Total max dose 1000 mg. No repeat dose. Use for mild pain (score 1-3), moderate pain (score 4-6), or severe pain (score 7-10**)** – no severe hepatic impairment, active liver disease or allergy.				X	
KETOROLAC: For abdominal, back or extremity pain, 15 mg, IN/IM/IV/IO. **Ketorolac is not to be used in patients under 2 or over 65.**				X	

	F	E	O	P	D
†**FENTANYL:** 1-2 mcg/kg, maximum of 3 mcg/kg, IV/IO/IM/IN. If initial dose given IV/IO/IN, may repeat in 5 minutes, or if initial dose given IM may repeat in 10 minutes. Repeat doses at 0.5 mcg/kg. Use for moderate pain (score 4-6) or severe pain (score 7-10). Fentanyl is to be used with caution in patients taking narcotics, benzodiazepines**,** MAOIs, conivaptan, crizotinib, linezolid, nalbuphine, pazopanib, pentazocine, sibutramine, sodium oxalate, rifampin/ isoniazid.				X	
***MORPHINE:** Titrate in 2 – 5 mg increments IV/IO every 3 – 5 minutes (if systolic BP > 90 mmHg). If no IV/IO available, 5 – 10 mg IM, which may be repeated in 20 minutes. Maximum total dose 30 mg.				X	
KETAMINE: Mix 0.3 mg/kg (max. 30 mg) in 50 – 100 mL normal saline or D5W and label bag. Administer slowly over five (5) minutes. Place "KETAMINE ADMINISTERED" band on patient's wrist. May repeat for severe pain fifteen (15) minutes after medication infusion finishes.				X	
BASE CONTACT: for approval of higher morphine dose if indicated.					X
MIDAZOLAM: 0.5 – 1 mg increments titrated to patient's pain or spasm up to 5 mg IV/IO/IN. If no IV access available, 2 – 10 mg IM, 10 mg maximum.				X	

USE WITH CAUTION IN PATIENTS WITH

- Head trauma* †
- Altered mental status* †
- ETOH intoxication* †
- Decreased respirations*†
- Blood pressures < 90mmhg systolic*
- Elderly patients* †

AVOID THE USE OF MORPHINE AND FENTANYL CONCURRENTLY: If a patient experiences an adverse effect from one of these medications, the patient is experiencing unrelenting severe pain, and the transport time is extended, changing to the alternate medication may be appropriate with Base Hospital Physician consultation.

POLICY: 554.46
TITLE: Nausea

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NAUSEA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
The purpose of this protocol is to assist patients who have uncontrollable nausea with extended transport times and/or patients who have nausea from the administration of narcotics.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress.	X	X	X	X	
ECG MONITOR: as appropriate. Lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
***ONDANSETRON:** 4 mg IM/IV/IO, or 4 mg Oral Disintegrating Tablet (ODT) for nausea and/or vomiting. May be repeated twice, not to exceed 12 mg.				X	
****DIPHENHYDRAMINE:** 25 mg IM/IO or slow IV. May be repeated once to a maximum of 50 mg.				X	

***PRECAUTIONS FOR ONDANSETRON:**

- Known Sensitivity to Ondansetron (Zofran) or other 5-HT-3 antagonists.
  - Granisetron (Kytril)
  - Dolasetron (Anzemet)
  - Palonosetron (Aloxi)

**** PRECAUTIONS FOR DIPHENHYDRAMINE:**

- **USE WITH CAUTION IN PATIENTS WITH:**
  - Barbiturates, opiates, hypnotics, tricyclic antidepressants, MAOIs & alcohol.
  - CNS depression
  - Asthma
  - Pregnancy
- **WATCH CLOSELY FOR:**
  - Mouth dryness
  - Respiratory depression
  - Vomiting
  - Hypotension
  - Slurred speech
  - Allergic reaction

POLICY: 554.48
TITLE: Hypertension

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HYPERTENSION

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Malignant Hypertension: BP > 220 systolic or > 120 diastolic when accompanied by signs of serious organ damage such as: coronary ischemic discomfort, pulmonary edema, severe headache, vomiting, altered mental status, seizures, hematuria and generalized edema.

Pre-Eclampsia & Eclampsia: Pregnancy (usually > 20 weeks) or up to 6 weeks postpartum, BP > 140/110, confusion, headache, tremor, visual disturbances, epigastric pain, coma or diastolic BP > 100 even in the absence of other findings. Seizure activity indicates progression from pre-eclampsia to eclampsia.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	

Caution should be exercised in stroke victims, especially patients with long-standing high blood pressure. Rapid blood-pressure reduction can aggravate brain ischemia.

Consider:

- 554.09 CORONARY ISCHEMIC CHEST DISCOMFORT
- 554.10 ACUTE PULMONARY EDEMA
- 554.25 ACUTE CEREBROVASCULAR ACCIDENT
- 554.72 PREECLAMPSIA

POLICY: 554.51
TITLE: Poisoning

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

POISONING

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Includes: Caustics/corrosives (alkalis, acids, oxidizers), petroleum distillates, and organophosphates

In the event of a release of nerve agents or organophosphates, notify dispatch to request the MHOAC order CHEMPACK.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

NOTE: DO NOT INDUCE VOMITING

ALL POISONINGS	F	E	O	P	D
PROTECT FROM CONTAMINATION	X	X	X	X	
DECONTAMINATION • Remove contaminated clothing. • If agent is dry, brush off. If agent is liquid, flush with copious amounts of water. • If the eyes are contaminated flush with saline for at least 20 minutes.	X	X	X	X	
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilation as appropriate with appropriate airway adjuncts. Observe for airway burns.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
***OXYGEN**: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	

****ONDANSETRON:** 4 mg IM, slow IV, or 4 mg Oral Disintegrating Tablet (ODT) for nausea and/or vomiting. May be repeated twice. Max dose 12 mg.				X	
CARBON MONOXIDE					
OXYGEN: 15-LPM via non-rebreather or BVM.	X	X	X	X	
CPAP: as indicated.				X	
ORGANOPHOSPHATES					
CONSIDER ATROPINE: 2-5 mg increments IV/IO or 2 mg IM. Repeat every 5 minutes as needed to control secretions, bradycardia, bronchorrhea, and dysrhythmia.				X	
MIDAZOLAM for seizures: Do not delay for IV/IO access. Closely monitor respirations/airway and support ventilation as indicated. • IM/IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO - 1-2 mg every 2 minutes until seizure stops or max 10 mg.				X	
NASOGASTRIC TUBE: suction gastric contents – only if patient has advanced airway and oral ingestion has occurred within 60 minutes.				X	
CAUSTICS/CORROSIVES/PETROLEUM DISTILLATES					
NASOGASTRIC TUBE: suction gastric contents – only if patient has advanced airway and oral ingestion has occurred within 60 minutes.				X	

*** Use oxygen with caution near any hazardous materials**

****PRECAUTIONS FOR ONDANSETRON:**
• Known Sensitivity to Ondansetron (Zofran) or other 5-HT-3 antagonists.
- Granisetron (Kytril)
- Dolasetron (Anzemet)
- Palonosetron (Aloxi)

CARBON MONOXIDE

- Carbon monoxide is an odorless, colorless, tasteless toxic gas. Carbon monoxide poisoning is easily misdiagnosed as flu-like symptoms, fatigue, or other general complaints. Common sources of carbon monoxide include motor vehicles, structure and wildland fires, gas-powered machines operating in closed spaces, improperly functioning wood-burning stoves, heaters, or furnaces and industrial sites. Untreated carbon monoxide may result in short and long-term health consequences.
- Refer to 554.81 BURNS and 554.82 TRAUMA AND TRAUMATIC SHOCK as indicated

CAUSTIC CORROSIVES

- **Alkalis:** sodium hydroxide (caustic soda), drain cleaners, potassium hydroxide, ammonium hydroxide (fertilizers), lithium hydroxide (photographic chemicals, alkaline batteries), calcium hydroxide (lime).
- **Acids:** hydrofluoric acid (which may have a delayed onset of symptoms), sulfuric acid (battery acid), hydrochloric acid.
- **Oxidizers:** bleach, potassium permanganate.
- Refer to 554.81 BURNS and 554.82 TRAUMA AND TRAUMATIC SHOCK as indicated

ORGANOPHOSPHATE

- May cause bronchospasm, an increase in pulmonary and nasal secretions, constricted pupils, vomiting, diarrhea, urinary incontinence, diaphoresis, and cardiac dysrhythmias including both bradycardia and AV blocks.
- Remember the most spectacular signs by the following mnemonic: (**S**alivation, **L**acrimation, **U**rination, **D**efecation, **G**astric upset, **E**mesis and **M**iosis - **SLUDGEM**.)
- Other useful mnemonics are, "**MUDDLES**:" **M**iosis, **U**rination, **D**efecation, **D**iaphoresis, **L**acrimation, **E**mesis, **S**alivation; and "**DUMBBELS"**: **D**iarrhea, **U**rination, **M**iosis/muscle weakness, **B**ronchorrhea, **B**radycardia, **E**mesis, **L**acrimation, **S**alivation/sweating.

POLICY: 554.52
TITLE: Dystonic Reactions to Phenothiazines

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

DYSTONIC REACTIONS TO PHENOTHIAZINES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
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Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
DIPHENHYDRAMINE: 25-50 mg IV/IO/IM titrated to relief of signs and symptoms. **(FOR DYSTONIC REACTIONS ONLY).**				X	
CONSIDER ACTIVATED CHARCOAL: 1 g/kg po if GCS is 15 or via NG tube if patient is intubated and oral ingestion has occurred within 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	
NASOGASTRIC TUBE: suction gastric contents only if patient is intubated and oral ingestion has occurred within 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	

NOTE: Dystonic reactions to phenothiazines may occur at normal dosing levels and the induction of vomiting is not recommended

POLICY: 554.54
TITLE: Overdose

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

OVERDOSE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

NOTE: DO NOT INDUCE VOMITING

	F	E	O	P	D
ASSESSMENT: look for serious signs and symptoms related to bradycardia or myocardial depression: systolic BP < 90, coronary type pain/discomfort, respiratory distress, pulmonary congestion, circulatory shock, CNS depression, ALOC. Critical patients are hypotensive and bradycardic.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	
† ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
***VASCULAR ACCESS:** IV/IO, rate as indicated.				X	
NASOGASTRIC TUBE: suction gastric contents only if patient is intubated and oral ingestion has occurred within 60 minutes.				X	
CONSIDER ACTIVATED CHARCOAL: 1 g/kg po if GCS is 15 or via NG tube if patient is intubated and oral ingestion has occurred within 60 minutes.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.	X	X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	

BETA BLOCKERS	F	E	O	P	D
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM. Repeat every 3 - 5 minutes as needed. Maximum total dose of 3 mg.				X	
TRANSCUTANEOUS CARDIAC PACING: Place pacing pads on the Anterior/Posterior of thorax if possible. If patient remains hemodynamically unstable with serious signs & symptoms, DO NOT delay TCP waiting for vascular access or for atropine to take effect.				X	
PAIN MANAGEMENT: • **FENTANYL**: 1 – 2 mcg/kg IV/IO/IM/IN. If initial dose given IV/IO/IN, may repeat in 5 minutes, or if initial dose given IM may repeat in 10 minutes. Repeat doses at 0.5 mcg/kg. Maximum total 3 mcg/kg. • **MIDAZOLAM:** 0.5 – 1 mg increments IV/IO/IM/IN titrated to patient's pain or spasm up to 2 mg. Hold for SBP < 100.				X	
CALCIUM CHANNEL BLOCKER					
CALCIUM CHLORIDE: 100 mg IV push over 2 minutes if systolic BP < 90 and HR < 60. Repeat doses of 100 - 200 mg IV over 2 - 4 minutes, if hypotension and bradycardia persist.				X	
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM. Repeat every 3 - 5 minutes as needed. Maximum total dose of 3 mg.				X	
TRICYCLIC ANTIDEPRESSANTS					
SODIUM BICARBONATE • 1 mEq/kg slow IV push for cardiac dysrhythmia or QRS complex wider than 0.10 second. Repeat as indicated until QRS ≤ 0.10 seconds. **OR** • Infusion**:** Mix 100 mEq in1000 mL NS. Start at 150 gtt/min (mL/hr), titrate up for cardiac dysrhythmia or QRS complex wider than 0.10 sec.				X	
****MIDAZOLAM FOR SEIZURE:** Do not delay for IV/IO access. Closely monitor respirations/airway and support ventilation as indicated. • IM – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO - 1-2 mg every 2 minutes until seizure stops or max 10 mg.				X	
OPIOID					
VENTILATE: With oxygen and BVM if hypoventilation, goal ≥ 94%.	X	X	X	X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.4 - 2 mg IV/IO//IM; may repeat to a total of 12 mg. If opioid overdose is suspected, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg.				X	
ALL HYPOTENSION					
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	

***Administer fluid boluses with caution due to the high incidence of pulmonary edema in tricyclic overdose patients.**

****Most tricyclic overdose seizures are short in duration and do not require midazolam.**

† Maximize naloxone doses prior to attempting advanced airway placement, if narcotic overdose is suspected.

POLICY: 554.61
TITLE: Stings-Bites-Envenomation

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

STINGS-BITES-ENVENOMATION

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SCENE SAFETY	X	X	X	X	
ASSESSMENT	X	X	X	X	
IDENTIFY CAUSE: if feasible and safe to do so, have animal transported for identification purposes. • **Bee/Wasp sting:** remove (scrape away) stinger. Cold packs may be applied to relieve pain. • **Spider bite/Scorpion sting**: **r**emove stinger. Cold packs may be applied to relieve pain. • **Snake envenomation:** avoid movement of the affected extremity, keeping extremity at or below heart level. **DO NOT APPLY ICE**. Monitor distal pulses. Circle any swelling and/or discoloration around bite mark(s) with a pen and note time. This measurement can be used as a baseline for determining the progress of swelling.	X	X	X	X	
PULSE OXIMETRY: apply and monitor		X	X	X	
CAPNOGRAPHY: apply and monitor				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
MIDAZOLAM: if suspected Black Widow Spider bite and muscle spasms, refer to 554.44 PAIN MANAGEMENT as indicated.				X	

POLICY: 554.62
TITLE: Hypothermia - Frostbite

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HYPOTHERMIA - FROSTBITE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Patients with severe hypothermia may appear dead (pulseless, absent respiration, and fixed pupils) but still have cardiac electrical activity.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

USE EXTREME CAUTION WHEN MOVING PATIENT

Moderate Hypothermia (92°-95° F/ 33°-35° C) **Severe Hypothermia (Core temp < 92° F / < 33° C)**	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
WARMING MEASURES: remove wet clothing and cover with warm dry blankets. Use ambient heat and heat packs as able.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated with warm fluids.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 1 mg IM if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat 1 mg IM.				X	

FROSTBITE (skin is white, numb or burning, soft to touch and does not re-color with touch)					
	F	E	O	P	D
EVALUATE: for hypothermia and treat as indicated.	X	X	X	X	
WARMING MEASURES: move patient to warm environment & wrap affected extremity with thick, warmed blankets or clothing. **DO NOT RUB AFFECTED EXTREMITY & AVOID CHEMICAL HEAT PACKS.**	X	X	X	X	
PAIN MANAGEMENT: Refer to 554.44 PAIN MANAGEMENT as indicated.				X	

POLICY: 554.64
TITLE: Heat Illness

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HEAT ILLNESS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Heat Cramps/Exhaustion: Muscle cramping, dizziness, exhaustion, nausea, vomiting, weakness, headache, diaphoresis, normal or slightly elevated body temperature. Syncope and an altered level of consciousness may occur.
Heat Stroke: Altered level of consciousness, elevated body temperature, usually > 104ºF (40ºC), tachycardia, and hypotension.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

HEAT CRAMPS - HEAT EXHAUSTION	F	E	O	P	D
ASSESSMENT	X	X	X	X	
COOLING MEASURES: place patient in a cool environment.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: 500 mL fluid bolus. Reassess after each bolus and repeat bolus as indicated. Use cooled IV fluids as available.				X	

HEAT STROKE					
AS ABOVE AND ADDITIONALLY:	F	E	O	P	D
COOLING MEASURES: In order of effectiveness, use dependent on availability of resources: 1. If on scene at an event where staff have initiated cold water immersion (CWI) for suspicion of heat stroke, do not move the patient from cold water immersion until patient starts shivering or 15-20 minutes of immersion, whichever is soonest. Ideal core temperature, if available, would be 102◦F (39◦C) or less when CWI is discontinued. 2. If CWI not available but cool/cold water is, remove clothing and rotate cool/cold wet towels over entire body of patient. 3. If CWI and cool/cold wet towels not available, remove clothing, splash/sponge patient with water and place cool packs on neck, axillary, and inguinal areas. Promote evaporative cooling by fanning.	X	X	X	X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex	X	X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
MIDAZOLAM: Do not delay for IV/IO access. • IM/IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO – 1-2 mg every 2 minutes until seizure stops or max 10 mg.				X	

POLICY: 554.65
TITLE: Non-Fatal Drowning

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NON-FATAL DROWNING

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Drowning or near drowning patients may also have significant head, neck, and back injuries. Strongly consider spinal immobilization when a history of jumping or diving into the water exists, or the history is unclear.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SPINAL MOTION RESTRICTION: as indicated.	X	X	X	X	
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
CPAP: as indicated.				X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 Rx GUIDELINES				X	
Refer to 554.62 HYPOTHERMIA - FROSTBITE as indicated	X	X	X	X	

POLICY: 554.71
TITLE: Childbirth

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CHILDBIRTH

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
TRANSPORT: mother placed on left side.	X	X	X	X	
DELIVER NEWBORN: if no time for transport, proceed with delivery. Use hand to prevent explosive delivery. If cord is wrapped around neck & cannot be slipped over the newborn's head, double clamp & cut between clamps. Complete delivery of newborn's body. Dry newborn & keep warm, place newborn on mother's abdomen or breast. Allow cord to stop pulsating, then clamp and cut 6-8 inches from newborn. Consider delayed cord clamping (60 seconds) if newborn is stable.	X	X	X	X	
ASSESS NEWBORN: assess APGAR score at 1 & 5 minutes.	X	X	X	X	
MASSAGE FUNDUS: following delivery of placenta.	X	X	X	X	
OXYTOCIN: following delivery of the placenta for postpartum hemorrhage and all twins, triplets, etc. 20 units/1000 mL NS. Bolus 500 mL over 30 minutes, then infuse at a rate of 250 ml per hour. **OR** 10 units IM.			X	X	
TRANEXAMIC ACID: 1 gm in 100 mL of NaCl infused over 10 minutes IV/IO for profuse postpartum bleeding following delivery of the placenta and for all multiple births.				X	
BREECH PRESENTATION					
DELIVER NEWBORN: for a buttock presentation, allow newborn to deliver to the waist without active assistance (support only). Use hand to prevent explosive	X	X	X	X	

delivery. When legs & buttocks are delivered, the head can be assisted out. If the head does not deliver within 4-6 minutes, insert gloved hand into vagina, palm towards baby's face & cord between fingers, & create an airway.					
TRANSPORT: while retaining airway for newborn if head undelivered.	X	X	X	X	
PROLAPSED CORD					
	F	E	O	P	D
POSITION: place the mother in shock position with her hips elevated on pillows or knee chest position.	X	X	X	X	
PROTECT UMBILICAL CORD: insert gloved hand into vagina & gently push presenting part off the cord. Cover exposed portion of cord with saline soaked gauze. Do not try to push cord back into vagina.	X	X	X	X	
TRANSPORT: while protecting the umbilical cord.	X	X	X	X	

APGAR SCORE	0	1	2
APPEARANCE	Blue	Pink Body/Blue Limbs	All Pink
PULSE	Absent	< 100/Min	>100/Min
GRIMACE	None	Grimace	Cough/Sneeze
ACTIVITY	Limp	Some Flexion	Active Motion
RESPIRATIONS	Absent	Slow/Irregular	Good

POLICY: 554.72
TITLE: Preeclampsia/Eclampsia

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PREECLAMPSIA/ECLAMPSIA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Preeclampsia is defined by the elevation of the expectant mother's blood pressure, usually after the 20th week of pregnancy, and excessive protein in her urine. Signs & symptoms: headaches, abdominal pain especially right upper quadrant, shortness of breath, burning behind the sternum, nausea and vomiting, confusion, heightened state of anxiety and/or visual disturbances such as photophobia, blurred vision, seeing flashing spots or auras.

Eclampsia is a complication of preeclampsia characterized by seizures during pregnancy and up to six weeks post-partum. Eclampsia is rare and usually treatable if appropriate intervention occurs promptly. Left untreated, eclamptic seizures can result in coma, brain damage, and possibly maternal or infant death.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion or seizures.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	

	F	E	O	P	D
PRE-ECLAMPSIA					
TRANSPORT: Mother placed on left side if time permits. Try to maintain a quiet environment.	X	X	X	X	
ECLAMPSIA					
MAGNESIUM SULFATE: 6 gm in 100 mL of NS infused over 15 minutes IV/IO or 10 gm in divided doses IM.				X	
BASE CONTACT: if seizures continue after magnesium infusion.					X

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 4/15/2016
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

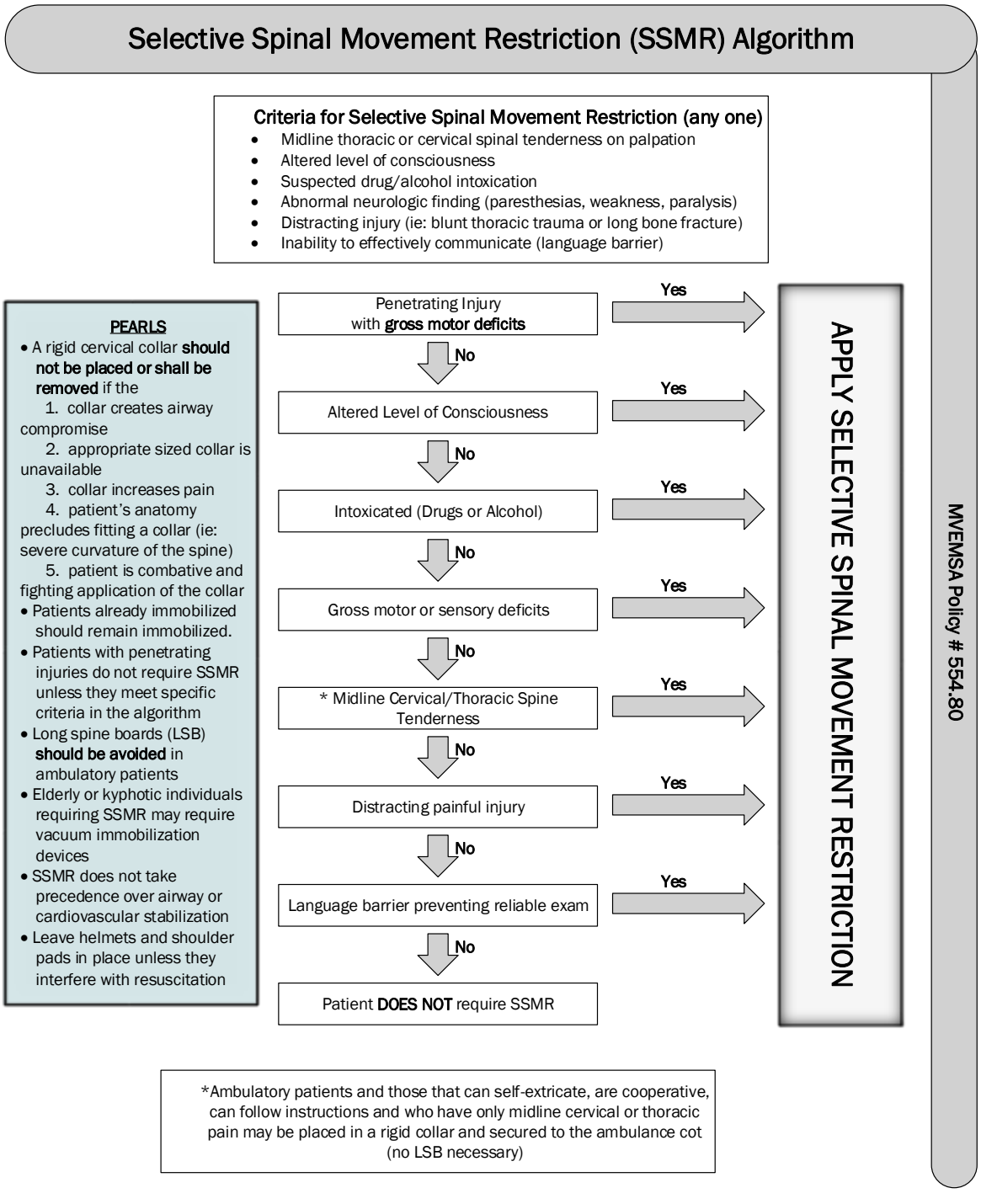
REVIEW DATE: 4/2021

SELECTIVE SPINAL MOVEMENT RESTRICTION (SSMR)

I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE: To serve as a patient treatment standard for EMTs, AEMTs and Paramedics within their scope of practice.

III. PROTOCOL: The term Selective Spinal Movement Restriction (SSMR) describes the process to care for patients with possible unstable spinal injuries. The purpose of SSMR is to: reduce gross movement of the patient, prevent duplication of the damaging mechanism to the spine and regular reassessment of motor/sensory function.



POLICY: 554.81
TITLE: Burns

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

BURNS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

USE TRAUMA TRANSPORT CRITERIA

	F	E	O	P	D
SCENE SAFETY: move patient to a safe environment.	X	X	X	X	
ASSESSMENT	X	X	X	X	
STOP BURNING PROCESS: • **CHEMICAL BURN** - brush off dry chemicals then flush with copious amounts of water. Consult container label for decontamination instructions and transport label with patient. • **TAR BURNS** - cool with water and transport; do not attempt to remove tar. • **THERMAL BURNS** - cool with water for up to 5 minutes to stop the burning process. Avoid prolonged cool water usage due to risks of hypothermia and local cold injury.	X	X	X	X	
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of respiratory distress or hypoperfusion. Consider high flow O_2 if CO exposure is suspected. If intubated, ventilate with bag-valve and 100% oxygen.	X	X	X	X	
INTUBATE: if facial or oral swelling and respiratory depression present, especially if the patient has a history of smoke exposure in a confined space.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
12-LEAD ECG: for electrical burn.				X	
VASCULAR ACCESS: IV/IO.				X	

	F	E	O	P	D
FLUID RESUSCITATION: for partial & full thickness burns surface area > 9%, consider 2 large bore IVs and 500 mL fluid bolus. Repeat bolus as needed to maintain systolic BP of 100. Consider warm IV fluids, unless hyperthermic.				X	
DRESS BURNS: • Thermal Burns with >20% body surface area, cover with dry dressing and keep patient warm. • Thermal Burns with <20% body surface area, apply moist dressing.	X	X	X	X	
PAIN MANAGEMENT: Refer to 554.44 PAIN MANAGEMENT				X	

POLICY: 554.82
TITLE: Trauma and Traumatic Shock

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TRAUMA AND TRAUMATIC SHOCK

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
CONTROL OBVIOUS BLEEDING	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if GCS is < 8 and not rapidly improving, consider: - SGA - or ETI			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry < 94% signs of respiratory distress or hypoperfusion. High flow oxygen for traumatic shock and/or traumatic brain injury.	X	X	X	X	
SPINAL MOTION RESTRICTION: if indicated. **NOT** indicated for penetrating spinal trauma.	X	X	X	X	
POSITION: if patient is > 6 months pregnant, place patient in left lateral decubitus position. If long spine board is indicated, tilt spine board 30° left lateral.				X	
WARM PATIENT: trauma patients are very susceptible to hypothermia, even in a warm environment.	X	X	X	X	
DRESS & SPLINT: as indicated.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, 2 large bore IVs. Rate as indicated.				X	
FLUID BOLUS: administer NS boluses as indicated to a SBP range of ≥ 100. Use warm IV fluid if available. Reassess the patient after each bolus.				X	
***TRANEXAMIC ACID:** 1 gm in 100 mL of NS infused over 10 minutes.				X	

TEST FOR GLUCOSE		X	X	X	
	F	E	O	P	D
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.		X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 1 mg IM if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat 1 mg IM.				X	
PAIN MANAGEMENT: Refer to 554.44 PAIN MANAGEMENT				X	
TRANSPORT: per trauma triage protocol.	X	X	X	X	
NEUROGENIC SHOCK					
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 100 • Mix 1 mL of Epi 1:10,000 (0.1mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 100 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.				X	
HEAD – NECK – FACIAL TRAUMA					
POSITION: place head injured patients in reverse Trendelenburg (elevate the head 15-20°) if patient exhibits no signs of shock. If patient is > six months pregnant, see positioning above.	X	X	X	X	
CHEST TRAUMA					
NEEDLE THORACOSTOMY: for tension pneumothorax, on affected side(s) between 2nd & 3rd intercostal space midclavicular line **OR** between 4th & 5th intercostal space midaxillary line. Place catheter just above the rib to avoid intercostal artery. Repeat if suspected catheter occlusion. Perform on both sides if unable to isolate affected side.				X	
EXTREMITY TRAUMA					
HEMOSTATIC GAUZE: if hemorrhage is not controlled by basic intervention.		X	X	X	
TOURNIQUET: if hemorrhage is not controlled by basic intervention.	X	X	X	X	
DRESS & SPLINT • Splint dislocations in position found. • Return injured extremities (non-dislocations) to anatomic position as resistance and pain allows. • Check neurovascular status prior to & after each extremity manipulation. • Cover exposed bone with saline soaked gauze. Do not reduce exposed bone back into wound. • Grossly angulated long bone fractures may be reduced with gentle unidirectional traction for splinting.	X	X	X	X	
TRACTION SPLINT: for mid-shaft femur fracture. Check neurovascular status prior to and after each extremity manipulation.		X	X	X	
ALL TRAUMA PATIENTS					
TRANSPORT: per trauma triage protocol.	X	X	X	X	

* TXA should be administered to trauma patients who meet the following criteria, unless otherwise indicated:

1. Systolic BP of < 100 mmHg.
2. Uncontrolled bleeding.
3. Time of injury < 3 hours.

CONSIDERATIONS:

NEUROGENIC SHOCK:

- Consider neurogenic shock when hypotensive, bradycardic, after possible spinal cord injury or TBI.

HEAD – NECK – FACE:

- **Avulsed Tooth** - replace tooth in socket (if adult tooth and patient is conscious and alert) or place tooth in milk, normal saline, saline soaked gauze, or a commercially available "tooth saver."
- **Eye Injuries** - Stabilize or dress both eyes in place with saline soaked gauze or use cup or eye shield. Avoid applying direct pressure to eye and do not attempt to replace partially torn globe.
- **Impaled Object** - Immobilize and leave in place. Remove object only upon Base Physician order or if it interferes with CPR or if the object is impaled in the face, cheek, or neck and is compromising ventilation.

CHEST

- **Impaled Object:** Immobilize object and leave in place. Remove object only upon Base Physician order or if object interferes with CPR.
- **Flail Chest:** Stabilize chest. Observe for tension pneumothorax. Consider assisted ventilation.
- **Open Chest Wound:** Cover wound with occlusive dressing. If patient is being artificially ventilated, dress wound loosely (do not seal). Continuously reevaluate patient to watch for the development of a tension pneumothorax.
- **Cardiac Tamponade:** If the patient has a systolic BP < 100, administer 250 mL fluid boluses as indicated. Reassess the patient after each bolus.
- **Cardiac Contusion:** Monitor for dysrhythmia. Refer to Cardiac GUIDELINES.

ABDOMINAL

- **Impaled Object** - Immobilize and leave in place. Remove object only upon Base Physician order or if object interferes with CPR.
- **Eviscerating Trauma** - Cover eviscerated bowels and organ with saline soaked gauze. **Do not attempt to replace bowels or organs into the abdominal cavity.**
- **Genital Injuries** - Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding.
    - Treat genital amputation the same as extremity amputation, refer to Extremity

EXTREMITY

- **Amputations**: If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in saline soaked gauze, place in container or bag. Place container or bag in ice, if possible. **Do not place amputated part directly on ice.**
- **Tourniquet application:**
    - The tourniquet should be applied onto bare skin to prevent slipping.
    - Place the tourniquet as low on the limb as possible, above the wound and above the joint.
    - A 2nd tourniquet may be placed just above the first if bleeding is not controlled with a single tourniquet. If an extremity amputation, the 2nd tourniquet can be placed just above the wound.
    - The tourniquet is tightened with the aim of stopping a distal pulse.
    - The tourniquet is clearly marked including time and date of application.

POLICY: 554.83
TITLE: Traumatic Arrest

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TRAUMATIC ARREST

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
HP-CPR: including AED. Use mechanical compression device if available or switch CPR providers every 2 minutes. Avoid interruption.	X	X	X	X	
HEMOSTATIC GAUZE: if hemorrhage is not controlled by basic intervention.		X	X	X	
TOURNIQUET: if hemorrhage is not controlled by basic intervention.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	

ECG MONITOR:
• Assess rhythm.
  ○ If asystole, discontinue resuscitation efforts.
  ○ **Complete Traumatic Arrest Protocol and refer to appropriate cardiac guidelines.** Lead placement may be delegated.
				X	

TRANSPORT: if within 5 minutes of nearest hospital.	X	X	X	X	
ADVANCED AIRWAY: • Consider SGA. • If ROSC achieved and no SGA in place, ETI.			X	X X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: ventilate with 100% oxygen.	X	X	X	X	
NEEDLE THORACOSTOMY: insert bilaterally between 2nd & 3rd intercostal space midclavicular line OR between 4th & 5th intercostal space midaxillary line. Place catheter just above the rib to avoid the intercostal artery. Repeat if suspected catheter occlusion.				X	

	F	E	O	P	D
VASCULAR ACCESS: IV/IO. Establish at least 2 large bore IVs and administer 1 liter NS bolus. Additional boluses as indicated to SBP ≥ 90. Reassess after each bolus.				X	
IF ROSC					
SPINAL MOTION RESTRICTION	X	X	X	X	
TRANSPORT	X	X	X	X	
***TRANEXAMIC ACID:** 1 gm in 100 mL of NS infused over 10 minutes.				X	
DRESS & SPLINT: as indicated.	X	X	X	X	
IF NO ROSC					
****TERMINATION OF RESUSCITATION:** • NOT hypothermic, • NOT victim of submersion, • NOT obviously pregnant, • Reversible causes treated, • NO ROSC after 5 two-minute cycles of HP-CPR performed				X	

* TXA should be administered to trauma patients who meet the following criteria, unless otherwise indicated:

1. Systolic BP of less than 90 mmHg.
2. Uncontrolled bleeding.
3. Time of injury < 3 hours.

****Refer to Policy #570.20, DETERMINATION OF DEATH IN THE PREHOSPITAL SETTING**

POLICY: 554.84
TITLE: Crush Injury

EFFECTIVE: 6/20/2025
REVIEW: 6/20/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CRUSH INJURY

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMR's, EMT's and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F= First Responder/EMR E= EMT O=EMT Local Optional SOP
P= Paramedic D= Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
CONTROL OBVIOUS BLEEDING	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
ADVANCED AIRWAY: if patient's GCS is less than 8 and not rapidly improving, consider SGA or ETI.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	
ECG MONITOR: as soon as access allows. Lead placement may be delegated. Treat as indicated.				X	
PRIOR TO RELEASE OF COMPRESSION	F	E	O	P	D
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: administer 250 mL NS boluses as indicated to SBP ≥ 90. Reassess after each bolus.				X	
***TRANEXAMIC ACIDS:** 1 gm in 100 mL of NS infused over 10 minutes.					
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists. If patient intubated, administer inhaled medication through aerosol holding chamber. Repeat as indicated.				X	

• **ALBUTEROL:** 2-10 inhalations via metered dose inhaler or 2.5 mg via nebulizer. If patient intubated, administer dose through aerosol holding chamber. • **LEVALBUTEROL**: 1.25 mg via nebulizer.					
BASE CONTACT: consult if able prior to release of compression for orders					X
DURING OR AFTER RELASE OF COMPRESSION	F	E	O	P	D
REASSESS: control obvious bleeding	X	X	X	X	
HYPERKALEMIA: DO NOT GIVE MEDICATIONS IN SAME IV LINE Suspect if compression ≥ 4 hours and peaked "T" wave, absent "P" wave, or widened "QRS". • **CALCIUM CHLORIDE:** 1 gm IV/IO over 5 minutes, followed by 20mL NS flush • **SODIUM BICARBONATE:** mix 100mEq in 1000 mL NS wide open.				X	
SPINAL MOTION RESTRICTION: if indicated.	X	X	X	X	
POSITION: Trendelenburg if tolerated. If long spine board is indicated, tilt spine board 30 degrees. If patient is > 6 months pregnant, place patient in left lateral decubitus position.	X	X	X	X	
TRANSPORT: per trauma triage protocol.	X	X	X	X	
PAIN MANAGEMENT: Refer to MCEMSA PAIN MANAGEMENT #554.44				X	

*TXA should be adminsiterd to trauma patients who meet the following criteria, unless otherwise indicated:

1. Systolic BP of < 90 mmHg.
2. Uncontrolled Bleeding.
3. Time of injury < 3 hours.

POLICY: 554.88
TITLE: Rx Guidelines

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Rx GUIDELINES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

EPINEPHRINE DRIP CHART

For a concentration of 4 mcg of epinephrine per milliliter solution.
1 mg of 1:1,000 mixed in 250 ml of NS

Mix 1mg of epinephrine 1:1,000 in 250ml = 4 mcg/ml	
1 mcg drip = 15 gtt/min	6 mcg drip = 90 gtt/min
2 mcg drip = 30 gtt/min	7 mcg drip =105 gtt/min
3 mcg drip = 45 gtt/min	8 mcg drip=120 gtt/min
4 mcg drip = 60 gtt/min	9 mcg drip=135 gtt/min
5 mcg drip = 75 gtt/min	10 mcg drip=150 gtt/min

*Based on a micro drip calibration of 60 drops equal to 1.0 milliliter.

LIDOCAINE DRIP CHART

For a concentration of 4 mg of lidocaine per milliliter solution.
1 g mixed in 250 ml of NS.

Mix 1g of lidocaine 1:1,000 in 250ml = 4 mg/ml	
1 mg drip = 15 gtt/min	2 mg drip = 30 gtt/min
3 mg drip = 45 gtt/min	4 mg drip =60 gtt/min

*Based on a micro drip calibration of 60 drops equal to 1.0 milliliter.

INTRANASAL MIDAZOLAM CHART

Patient age	Weight (kg)	Volume in ml (5 mg/ml)	Maximum Dose (mg)
Neonate	3 kg	0.3 ml	0.6 mg
<1 year	6 kg	0.4 ml	1.2 mg
1 year	10 kg	0.5 ml	2.0 mg
2 years	14 kg	0.7 ml	2.8 mg
3 years	16 kg	0.8 ml	3.2 mg
4 years	18 kg	0.9 ml	3.6 mg
5 years	20 kg	1.0 ml	4.0 mg
6 years	22 kg	1.0 ml	4.4 mg
7 years	24 kg	1.1 ml	4.8 mg
8 years	26 kg	1.2 ml	5.2 mg
9 years	28 kg	1.3 ml	5.6 mg
10 years	30 kg	1.4 ml	6.0 mg
11 years	32 kg	1.4 ml	6.4 mg
12 years	34 kg	1.5 ml	6.8 mg
Small teenager	40 kg	1.8 ml	8.0 mg
Adult/large teenager	> 50 kg	2.0 ml	10.0 mg

PEDIATRIC MEDICATION CHARTS

DO NOT EXCEED ADULT TOTALS

c = concentration

	Premie	NB	3 Mos.	6 Mos.	1 Yr	2 Yr	4 Yr	6 Yr	8 Yr	10 Yr	12 Yr
Body Length in cm	≤ 53	54-58	59-65	66-74	75-80	81-86	87-99	100-113	114-132	133-158	159-189
Av. Body Wt kg	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41
Act Charcoal c=6.25 g/oz. dose = 1 g/kg	1–2.5 g	2.5-4 g	6 g	7 g	10 g	12 g	16 g	20 g	25 g	34 g	41 g
Adenosine c = 3 mg/ml dose = 0.1 mg/kg	-	0.25–0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg
Albuterol 1 unit dose (3 ml of 0.083% solution)	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg	2.5 mg
Amiodarone c= 50 mg/ml dose= 5 mg/kg	-	12.5 - 20 mg	30 mg	35 mg	50 mg	60 mg	80 mg	100 mg	125 mg	170 mg	205 mg
Atropine IV c = 0.1 mg/ml dose = 0.02 mg/kg	-	.1 mg	0.12 mg	0.14 mg	0.2 mg	0.24 mg	0.32 mg	0.4 mg	0.5 mg	0.68 mg	0.82 mg
Dextrose (D10) dose = 5 ml/kg	5–12.5 ml	12.5 - 20 ml	30 ml	35 ml	50 ml	60 ml	80 ml	100 ml	125 ml	170 ml	205 ml
Dextrose (D25) dose = 2 ml/kg	2–5 ml	5 - 8 ml	12 ml	14 ml	20 ml	24 ml	-	-	-	-	-
Dextrose (D50) dose = 1 ml/kg	-	-	-	-	-	-	16 ml	20 ml	25 ml	34 ml	41 ml

Diphenhydramine c = 10 mg/ml dose = 1 mg/kg	1–2.5 mg	2.5 – 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg
Epi1:10,000 IV/IO dose = 0.01 mg/kg	0.01-0.025 mg	0.025 – .04 mg	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg
Epi1:1,000 IM dose = 0.01 mg/kg	-	-	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg

TRAUMA TRIAGE CRITERIA

1. Physiologic

- Glasgow Coma Score <14;
- Systolic blood pressure (Adult) < 90;
- Systolic blood pressure (Child 7-14) < 85;
- Systolic blood pressure (Child <6) < 70;
- Resp Rate < 10 or > 30 per min; • Resp Rate Infant <1yo: > 30 per min.

2. Anatomic

- Penetrating injuries to head, neck, torso, & extremities proximal to elbow & knee
- Flail chest
- Two or more proximal long bone fractures
- Crushed, degloved, or mangled extremity
- Amputation proximal to wrist &ankle
- Suspected pelvic fracture
- Open or depressed skull fracture
- Traumatic Paralysis

3. Mechanism of injury

- Falls (Adult) ≥ 20 ft (1 story = 10 ft)
- Falls (Child) ≥ 10 ft or 3X child's height
- High Risk Automobile Crash
  i) Intrusion > 12" at occupant site ii) Ejection from automobile iii) Unrestrained rollover iv) Vehicle telemetry
- Automobile vs. Pedestrian/Bicyclist
  i) Ped/bicyclist thrown or run over
  ii) Significant (> 20 mph) impact
- Motorcycle Crash > 20 mph

4. Special Considerations

- Older adults: age 55
- Anticoagulation or bleeding disorders
- Burns- Refer to burn triage criteria
- Death in same passenger compartment
- Renal disease requiring dialysis
- Pregnancy > 20 weeks with complaint of injury
- EMS provider judgment

Vision, Aphasia, Neglect (VAN) Scale

	Normal	Mild	Moderate	Severe
How weak is the Patient? Raise both arms.	No signs of weakness	Minor Drift	Severe drift- touches or nearly touches the ground	Flaccid or no antigravity

Visual Disturbances	Aphasia	Neglect
Field cut (which side) (4 quadrants)	Expressive (inability to speak or paraphasic errors); do not count slurred words (repeat & name 2 objects)	Forced gaze or inability to track to one side.
Double Vision (ask pt. to look to right then left; evaluate for uneven eyes)	Receptive (not understanding or following commands) i.e., close eyes, make a fist.	Unable to feel both sides at the same time, or unable to identify own arm.
Blind- New Onset	Mixed	Ignoring one side.
None	None	None

*Patient must have weakness and one or more of the V, A, N to be VAN Positive.

Sepsis Screen

Patient should be presumed to be septic if the patient meets two or more of the following criteria, with no other identifiable cause;

1. **Temperature > 100.4° or < 96°**
2. **Heart rate > 90**
3. **Respiratory rate > 20**

FIBRINOLYTIC CHECKLIST

Date_____PCR#_____Receiving Facility_____Patient Name

DOB_____Medic Unit_____If ANY of the following is checked YES, fibrinolysis MAY be contraindicated:

		YES	NO
1.	Chest pain lasting greater than 12 hours	( )	( )
2.	Systolic BP greater than 180 mmHg	( )	( )
3.	Diastolic BP greater than 100 mmHg	( )	( )
4.	Age younger than 35 if male or 40 if female	( )	( )
5.	History of stroke, TIA, brain tumor, A-V malformation or other CNS disease	( )	( )
6.	Internal bleeding in past 2-4 weeks	( )	( )
7.	Surgery or trauma in past 6 weeks, including laser eye surgery	( )	( )
8.	Closed head/facial trauma past 3 months	( )	( )
9.	Bleeding or clotting problems or on anticoagulants	( )	( )
10.	Pregnant female	( )	( )
11.	Terminal illness	( )	( )
12.	Serious systemic disease, including liver or kidney disease	( )	( )
13.	Previous hypersensitivity to reteplase	( )	( )

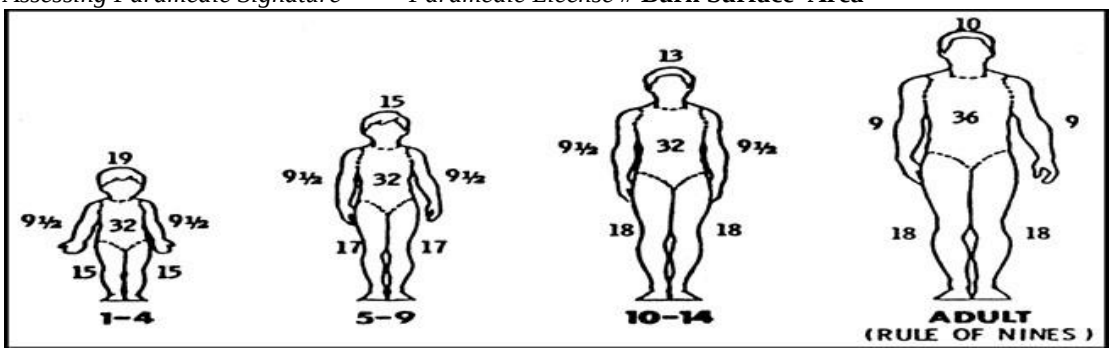
High Risk?

If any of the following are checked YES, consider transport to PCI facility:

		YES	NO
1.	Heart rate greater than or equal to 100 bpm AND SBP less than 100 mmHg	( )	( )
2.	Pulmonary edema (rales)	( )	( )
3.	Signs of shock (cool, clammy)	( )	( )

4. Contraindications to fibrinolytic therapy ( ) ( )

Assessing Paramedic Signature *Paramedic License #* **Burn Surface Area**



Rate based on a single micro infusion set, with drip calibration of 60 drops equal to 1.0 milliliter.

Rate based on a single macro infusion set drip, with calibration of 10 drops equal to 1.0 milliliter.

Rate based on two macro infusion sets, with drip calibration of 10 drops equal to 1.0 milliliter. Both IVs should be infusing at the prescribed drip rate.

Drip Rate Based on Surface Area Burned (2°& 3°) and Body Weight

Wt kg	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75
9%	15	30	45	45	60	75	90	100	100	100	20	25	25	30	30
9.5%	15	30	45	45	60	75	90	100	100	100	20	25	25	30	30
10%	15	30	45	45	100	100	90	100	100	20	25	25	30	30	30
15%	15	45	60	75	100	100	25	25	30	30	30	45	45	45	45
17%	30	45	60	90	100	20	25	30	30	45	45	45	45	45	60
18%	30	45	60	90	100	25	30	30	30	45	45	45	60	60	60
19%	30	45	75	100	100	25	30	30	30	45	45	45	60	60	60
24%	30	45	90	20	25	30	30	45	45	45	45	60	60	75	75
24.5%	30	45	90	20	25	30	30	45	45	45	60	60	60	75	75
28%	45	75	100	25	30	45	45	45	60	60	60	75	75	75	90
30%	45	75	100	25	30	45	45	45	60	60	60	75	75	90	90
32%	45	75	20	30	30	45	45	45	60	60	75	75	90	90	100
36%	45	90	25	30	45	45	60	60	60	75	75	90	90	100	100
37%	45	90	25	30	45	45	60	60	60	75	75	90	100	100	100
38%	45	100	25	30	45	45	60	60	75	75	75	90	100	100	100
39%	45	100	25	30	45	45	60	60	75	75	90	90	100	100	100
41.5%	45	100	25	45	45	60	60	75	75	90	90	100	100	60	60
45%	60	100	30	45	45	60	60	75	75	90	100	100	60	60	60
46%	60	100	30	45	45	60	60	75	75	90	100	100	60	60	60
47%	60	100	30	45	45	60	75	75	90	90	100	100	60	60	60
49%	60	20	30	45	45	60	75	75	90	100	100	60	60	60	75
51%	60	20	30	45	45	60	75	75	90	100	100	60	60	60	75
54%	60	25	30	45	60	60	75	90	100	100	60	60	60	75	75
54.5%	60	25	30	45	60	75	75	90	100	100	60	60	60	75	75
56.5%	75	25	45	45	60	75	75	90	100	100	60	60	75	75	90
58.5%	75	25	45	45	60	75	75	90	100	60	60	60	75	75	90
62%	75	25	45	45	60	75	90	100	100	60	60	75	75	90	90
63%	75	30	45	45	60	75	90	100	100	60	60	75	75	90	100
64%	75	30	45	45	60	75	90	100	60	60	60	75	75	100	100
66%	90	30	45	45	75	75	90	100	60	60	75	75	90	100	100
68%	90	30	45	60	75	75	100	100	60	60	75	75	90	100	100
71%	90	30	45	60	75	90	100	100	60	60	75	90	90	100	100
71.5%	90	30	45	60	75	90	100	100	60	75	90	90	90	100	100
75.5%	100	30	45	60	75	90	100	60	60	75	90	90	100	100	100
81%	100	30	45	60	75	100	100	60	75	75	90	100	100	100	120
82%	100	30	45	75	90	100	100	60	75	75	90	100	100	100	120
90.5%	100	45	60	75	90	100	60	75	75	90	100	100	100	120	150
91%	100	45	60	75	90	100	60	75	75	90	100	100	100	120	150
100%	20	45	60	90	100	60	60	75	90	100	100	100	120	150	150

Drip Rate Based on Surface Area Burned (2°& 3°) and Body Weight															
Wt kg	**80**	**85**	**90**	**95**	**100**	**105**	**110**	**115**	**120**	**125**	**130**	**135**	**140**	**145**	**150**
9%	30	45	45	45	45	45	45	45	45	45	45	45	60	60	60
9.5%	30	45	45	45	45	45	45	45	45	45	45	45	60	60	60
10%	30	45	45	45	45	45	45	45	45	45	45	60	60	60	60
15%	45	45	60	60	60	60	75	75	75	75	75	75	90	90	90
17%	60	60	60	60	75	75	75	75	75	90	90	90	100	100	100
18%	60	60	60	75	75	75	75	75	90	90	100	100	100	100	100
19%	60	60	75	75	75	75	90	90	90	90	100	100	100	100	100
24%	75	90	90	90	100	100	100	100	60	60	60	60	60	60	75
24.5%	75	90	90	90	100	100	100	100	60	60	60	60	60	60	75
28%	90	100	100	100	100	100	100	100	60	75	75	75	75	75	75
30%	100	100	100	100	60	60	60	60	75	75	75	75	75	90	90
32%	100	100	60	60	60	60	60	75	75	75	75	90	90	100	100
36%	60	60	60	60	75	75	75	75	90	90	90	100	100	100	100
37%	60	60	60	60	75	75	75	90	90	100	100	100	100	100	100
38%	60	60	60	75	75	75	75	90	90	100	100	100	100	100	100
39%	60	60	60	75	75	75	90	90	100	100	100	100	100	100	100
41.5%	60	60	75	75	75	90	90	100	100	100	100	100	100	120	120
45%	75	75	75	90	90	100	100	100	100	100	100	120	120	120	150
46%	75	75	75	90	100	100	100	100	100	100	120	120	120	120	150
47%	75	75	75	90	100	100	100	100	100	100	120	120	120	150	150
49%	75	75	90	100	100	100	100	100	100	120	120	120	150	150	150
51%	75	90	100	100	100	100	100	100	120	120	120	150	150	150	150
54%	90	100	100	100	100	100	100	120	120	150	150	150	150	150	150
54.5%	90	100	100	100	100	100	120	120	120	150	150	150	150	150	150
56.5%	90	100	100	100	100	100	120	120	150	150	150	150	150	150	150
58.5%	100	100	100	100	100	120	120	120	150	150	150	150	150	150	150
62%	100	100	100	100	120	120	150	150	150	150	150	150	150	150	150
63%	100	100	100	120	120	120	150	150	150	150	150	150	150	150	150
64%	100	100	100	120	120	120	150	150	150	150	150	150	150	150	WO
66%	100	100	100	120	120	150	150	150	150	150	150	150	150	150	WO
68%	100	100	120	120	150	150	150	150	150	150	150	150	150	WO	WO
71%	100	120	120	120	150	150	150	150	150	150	150	WO	WO	WO	WO
71.5%	100	120	120	150	150	150	150	150	150	150	150	WO	WO	WO	WO
75.5%	120	120	150	150	150	150	150	150	150	150	WO	WO	WO	WO	WO
81%	120	150	150	150	150	150	150	150	WO	WO	WO	WO	WO	WO	WO
82%	120	150	150	150	150	150	150	150	WO	WO	WO	WO	WO	WO	WO
90.5%	150	150	150	150	150	150	WO	WO	WO	WO	WO	WO	WO	WO	WO
91%	150	150	150	150	150	150	WO	WO	WO	WO	WO	WO	WO	WO	WO
100%	150	150	150	150	WO	WO	WO	WO	WO	WO	WO	WO	WO	WO	WO

ABBREVIATIONS

ALS:	Advanced Life Support
BLS:	Basic Life Support
BVM:	Bag Valve Mask
CHF:	Congestive Heart Failure
CNS:	Central Nervous System
CPAP:	Continuous Positive Airway Pressure
CWI:	Cold Water Immersion
D10:	Dextrose 10%
dL:	deciliter
ETI:	Endotracheal Intubation
GCS:	Glascow Coma Score
G:	Grams
HP-CPR:	High performance Cardiopulmonary Resuscitation
IM:	Intramuscular
IN:	Intranasal
IO:	Intraosseous
IV:	Intravenous
IVP:	Intravenous Push
J:	Joules
kg:	kilograms
mcg:	micrograms
mEq:	milliequivalent
mg:	milligrams
mL:	milliliters
NG:	Nasogastric
NS:	Normal Saline
NTG:	Nitroglycerin
ROSC:	Return of Spontaneous Circulation
ODT:	Oral Disintegrating Tablet
SBP:	Systolic Blood Pressure
SGA:	Supraglottic Airway
TCP:	Transcutaneous Pacing

Pediatric Treatment Guidelines

POLICY: 555.00
TITLE: General Pediatric

EFFECTIVE: 7/1/2018
REVIEW: 7/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PEDIATRIC

I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE: To serve as the treatment standard for EMRs,EMTs, AEMTs and Paramedics within their scope of practice.

III. PROTOCOL:

PEDIATRIC MEASUREMENTS - VITAL SIGNS

AGE	cm length	Weight (kg)**	Average Systolic BP	Pulse/ Minute	Resp./ Minute			Broselow Tape Color
Preemie	≤-53	< 2.5	60 - 70	> 120	60			White
Term NB	50 - 57	2.5 - 4	60 - 70	> 120	30 - 50			White
3 months	58 - 65	5 - 6	70 - 80	80-160	30 - 50			Pink
6 months	66 - 74	7	80 - 100	80-160	30 - 50			Pink - Red
1 year	75 - 86	10	80 - 100	80-160	24 - 40			Purple
2 year	87 - 100	12 - 14	94	80-130	24 - 32			Yellow
4 year	100 - 113	16 - 18	98	80-120	22 - 28			White
6 year	114 - 132	20 - 22	102	70-115	22 - 28			Blue
8 year	127 - 135	25 - 26	106	70-110	20 - 24			Orange
10 year	133 - 142	30 - 34	110	70-110	20 - 24			Orange-Grn
12 year	138 – 150	34 – 41	114	65-110	16 – 22			Green
13 year	155 – 165	41 – 50	118	65-110	16 – 22			X
14 year	161 – 170	50 – 56	122	65-110	16 – 22			X

**** Estimated Weight based upon predefined formula. To be used as a guide only and is NOT intended to replace the known or actual patient weight.**

Formulas for Systolic BP: 50th percentile BP for age over $2 \rightarrow Systolic\ \ BP = 90 + (2\ \ x\ \ age\ \ in\ \ yrs)$

Lower BP Limit $\rightarrow Systolic\ \ BP = 70 + (2\ \ x\ \ age\ \ in\ \ yrs)$

Formula for Weight: $kg = (2\ \ x\ \ age\ \ in\ \ yrs) + 10$

Abnormal Vital Signs

	Respiration	Pulse	Blood Pressure
Infant	> 90	> 190	< 60
Toddler	> 30	> 160	< 75
School Age	> 25	> 120	< 85
Adolescent	> 20	> 110	< 90

POLICY: 555.10
TITLE: Pediatric Newborn Resuscitation

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC NEWBORN RESUSCITATION

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

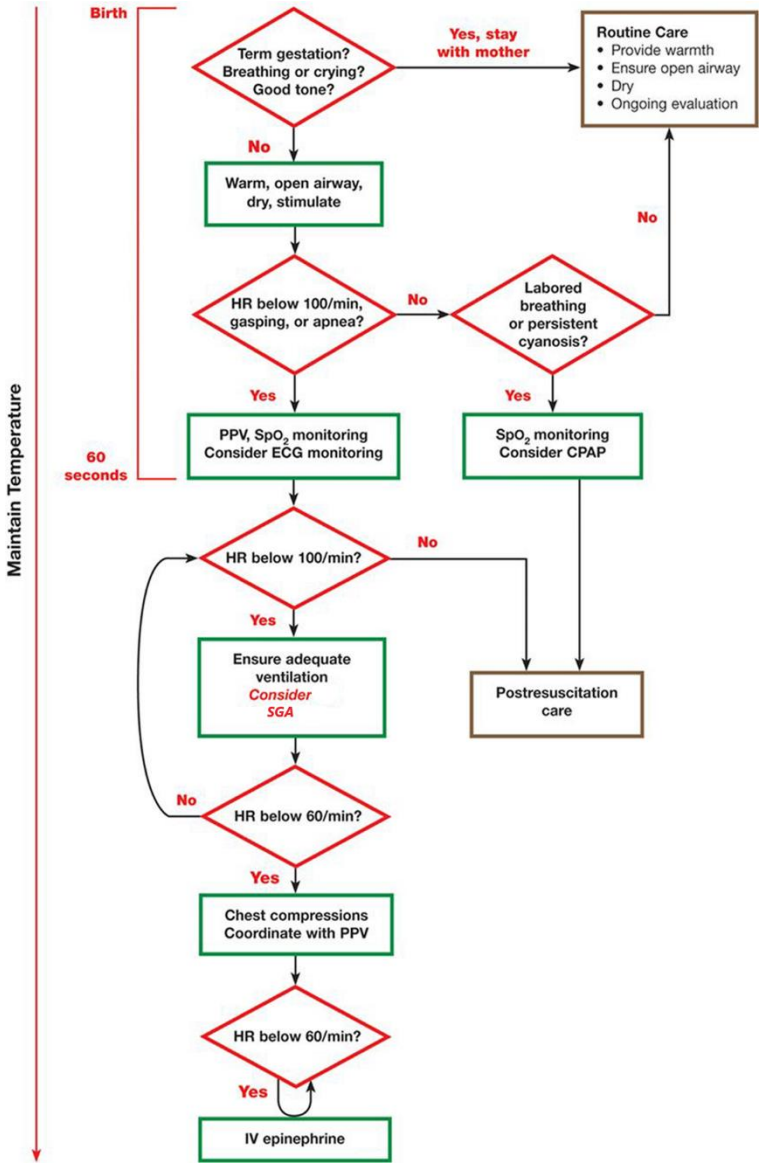
Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
SUCTION: position airway. Suction mouth & nasopharynx with bulb syringe.	X	X	X	X	
WARM: dry and keep warm with thermal blanket or dry towel. Stimulate by drying vigorously including the head and back.	X	X	X	X	
CLAMP and CUT CORD: leaving at least 2 inches of cord remaining. Consider delayed cord clamping (60 seconds) if newborn stable.	X	X	X	X	
ASSESS: evaluate breathing and heart rate. Perform APGAR score 1 and 5 minutes after delivery, if time allows. Do not delay resuscitative measures to score patient.	X	X	X	X	
HEART RATE > 100					
ASSESS COLOR: if peripheral cyanosis present, administer 100% oxygen via blow-by or mask.	X	X	X	X	
REASSESS: heart rate and respirations every 60 seconds.	X	X	X	X	
HEART RATE < 100					
OXYGEN: 100% via mask.	X	X	X	X	
STIMULATE	X	X	X	X	
REASSESS: if heart rate < 100 after 30 seconds of oxygen and stimulation, begin assisted ventilation with 100% oxygen via bag-valve mask, 40 - 60 breaths per minute.	X	X	X	X	
DEEP SUCTION: consider deep suction if meconium present. Limit suctioning to 5 seconds per attempt.			X	X	
REASSESS: heart rate and respirations every 30 seconds.	X	X	X	X	
ECG MONITOR: if heart rate not > 100 after 2 reassessments. Lead placement may be delegated.				X	

	F	E	O	P	D
HEART RATE < 60					
HP-CPR: including AED**.** If no increase in heart rate following ventilations, start compressions at 120 per minute. If patient's heart rate is increasing, continue ventilations without compressions for an additional 30 seconds.	X	X	X	X	
DEEP SUCTION: consider deep suction if meconium present. Limit suctioning to 5 seconds per attempt.				X	
SUPRAGLOTTIC AIRWAY: if compressions and ventilations fail to increase patient's heart rate. Ventilate with 100% oxygen via BVM.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
EPINEPHRINE: 0.01 mg/kg of 1:10,000 (0.1 mg/mL) IV/IO if heart rate fails to increase above 80.				X	
REASSESS: heart rate and respirations every 30 seconds.	X	X	X	X	
TEST FOR GLUCOSE		X	X	X	
D10: 2 mL/kg IV/IO if blood sugar < 40 mg/dL. Recheck glucose after 10 minutes and repeat infusion until blood sugar > 40 mg/dL.				X	

APGAR SCORE	**0**	**1**	**2**
APPEARANCE	Blue	Pink Body/Blue Limbs	All Pink
PULSE	Absent	< 100/Min	>100/Min
GRIMACE	None	Grimace	Cough/Sneeze
ACTIVITY	Limp	Some Flexion	Active Motion
RESPIRATIONS	Absent	Slow/Irregular	Good

NEWBORN RESUSCITATION ALGORITHM



POLICY: 555.11
TITLE: Pediatric Cardiac Arrest – Non-Traumatic

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC CARDIAC ARREST – NON-TRAUMATIC

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
HP-CPR: including AED. When available and appropriate, use mechanical compression device or switch CPR providers every 2 minutes. Avoid interruption.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
OXYGEN: ventilate with 100% oxygen.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus.				X	
EPINEPHRINE: 0.01 mg/kg of 1:10,000 (0.1 mg/mL) IV/IO push. Repeat every 3 – 5 minutes. Maximum of 1 mg per administration.				X	
VENTRICULAR FIBRILLATION - PULSELESS VENTRICULAR TACHYCARDIA					
DEFIBRILLATE: 1st time @ 2 joules/kg. Immediately restart CPR. Reassess rhythm every 2 minutes. Subsequent defibrillations @ 4 joules/kg.				X	
AMIODARONE: 5 mg/kg IV/IO, followed by 20 mL NS. Repeat twice at 5 minute intervals.				X	
LIDOCAINE: if refectory VF/VT 1 mg/kg IV/IO. Repeat every 3 – 5 minutes up to a total dose of 100 mg.				X	
MAGNESIUM SULFATE: For Torsade de Pointes 50 mg/kg IV/IO, maximum total dose of 2 gm.				X	

	F	E	O	P	D
CONSIDER					
TEST FOR GLUCOSE		X	X	X	
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose and repeat as needed.				X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.1 mg/kg IN/IM/IV/IO if mental status and respiratory effort are depressed and the child is not a newborn and there is a suspicion of opioid overdose. Maximum single dose 2 mg. Repeat every 5 minutes if indicated.				X	
IF ROSC					
12 LEAD ECG: treat as indicated.				X	
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with "epi" and the calculated concentration in mcg/mL • Give 1 mL (1 mcg/kg) every 1-2 minutes and titrate to age appropriate SBP				X	
	F	E	O	P	D
****TERMINATION OF RESUSCITATION:** If NOT hypothermic, victim of submersion, or obviously pregnant AND after 15 two-minute cycles of HP-CPR performed and minimum one dose of epinephrine, no ROSC AND asystole on the monitor AND reversible causes identified/treated.	X	X	X	X	

****Refer to Policy #570.20, Determination of Death in the Prehospital Setting**
Reference: 10/17/2022 EMS Termination Of Resuscitation And Pronouncement of Death - StatPearls - NCBI Bookshelf (nih.gov) https://www.ncbi.nlm.nih.gov/books/NBK541113/

During CPR

- Push hard (1/3 of Anterior-Posterior depth) and fast (at least 100/min)
- Ensure full chest recoil
- Minimize interruptions in chest compressions
- One cycle of CPR: 15 compressions then 2 breaths; 5 cycles = 1 – 2 min
- Avoid hyperventilation
- After advanced airway placement, give continuous chest compressions

CONSIDER CAUSES AND TREAT PER TREATMENT GUIDELINES

- Hypovolemia
- Hypoxia
- Hypo or Hyperkalemia
- Acidosis
- Toxins
- Cardiac Tamponade
- Tension Pneumothorax

POLICY: 555.14
TITLE: Pediatric Bradycardia

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC BRADYCARDIA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Bradycardia is characterized by a decrease in the rate of atrial depolarization due to slowing of the sinus node. The rhythm is regular or slightly irregular. Bradycardia is defined as heart rate < 80 in infants (< 1 year of age) and < 60 in children (1 year to 12 years of age). QRS complexes are normal, each preceded by a P wave.

NOTE: Most bradycardia in children is due to hypoxia.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
***CONSIDER HP-CPR**: if heart rate < 60, despite oxygen and ventilations if signs of poor perfusion.	X	X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus.					
EPINEPHRINE: 0.01 mg/kg of 1:10,000 (0.1 mg/mL) IV/IO. Repeat every 3-5 minutes. Maximum of 1 mg per administration.				X	
ATROPINE: 0.02 mg/kg IV/IO. May be repeated once. Minimum dose of 0.1 mg. Maximum single dose 0.5 mg.				X	

***During CPR**

- Push hard (1/3 of Anterior-Posterior depth) and fast (at least 100/min)
- Ensure full chest recoil
- Minimize interruptions in chest compressions
- One cycle of CPR: 15 compressions then 2 breaths; 5 cycles = 1 – 2 min
- Avoid hyperventilation
- After advanced airway placement, give continuous chest compressions

CONSIDER CAUSES AND TREAT PER TREATMENT GUIDELINES

- Hypovolemia
- Hypoglycemia
- Hypoxia
- Hypothermia
- Hypo or Hyperkalemia
- Acidosis
- Toxins
- Cardiac Tamponade
- Tension Pneumothorax

POLICY: 555.15
TITLE: Pediatric Tachycardia with Pulses

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC TACHYCARDIA with PULSES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
Sinus Tachycardia (QRS < 0.10 seconds) Heart Rate > 220 in infants or >180 in children					
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus.				X	
COOLING MEASURES: if temperature > 100.4°F (38°C). Remove clothing. Consider 555.44 PEDIATRIC SEPSIS.	X	X	X	X	

	F	E	O	P	D
Supraventricular Tachycardia (SVT) (QRS < 0.10 seconds) Heart Rate > 220 for ages < 2 or Heart Rate >180 for ages > 2. Absent or abnormal P waves					
VAGAL MANEUVERS: Consider if child has normal perfusion. • Infants and young children: ice water to face • Older children: Valsalva				X	
ADENOSINE: 0.1 mg/kg rapid IV/IO, up to 6 mg, if poor distal perfusion but is responsive. If no change, repeat at 0.2 mg/kg IV/IO, up to 12 mg. Maximum total dose 18 mg.				X	
SYNCHRONIZED CARDIOVERSION: 0.5 J/kg. If no response, repeat at 1 J/kg, repeat at 2 J/kg, then repeat at 4 J/kg.				X	
Wide Complex Tachycardia with Pulses (QRS ≥ 0.09 seconds) and Heart Rate > 150					
ADENOSINE: 0.1 mg/kg rapid IV/IO, up to 6 mg, if poor distal perfusion but is responsive. If no change, repeat at 0.2 mg/kg IV/IO, up to 12 mg. Maximum total dose 18 mg.				X	
MIDAZOLAM: 0.1 mg/kg IM/IN or slow IV/IO, maximum single dose 2 mg. • IV/IO: repeat every 5 minutes • IM/IN: repeat every 10 minutes • Repeat doses up to a maximum total of 5 mg IF THE PATIENT IS OBESE, DOSAGES SHOULD BE CALCULATED ON THE PATIENTS' IDEAL WEIGHT.				X	
SYNCHRONIZED CARDIOVERSION: 1 J/kg. If no response, repeat at 2 J/kg.				X	
ANTIARRHYTHMIC: choose **ONE** • **LIDOCAINE:** 1 mg/kg IV/IO, may be followed by 20-50 mcg/kg per minute. Repeat bolus if infusion delay is >15 minutes after the initial dose. • **AMIODARONE:** 5 mg/kg in 100 mL NS infused IV/IO over 20 minutes.				X	
SYNCHRONIZED CARDIOVERSION: 2 J/kg.				X	
BASE CONTACT: if rhythm unchanged.					X

NOTE:

1. Use standard size pediatric pads for cardioversion for children <10 kg. These should be placed on the anterior chest in a sternal-apical location. If pediatric paddles/pads are not available, use adult pads placed anterior posterior on the chest wall.
2. If the defibrillator is not able to deliver the indicated energy level, use the lowest setting available.

POLICY: 555.21
TITLE: Pediatric Airway Obstruction by Foreign Body

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC AIRWAY OBSTRUCTION BY FOREIGN BODY

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
If there is a history of a febrile illness and copious drooling, strongly consider epiglottitis. If epiglottis is suspected and patient is ventilating adequately, transport immediately and avoid visualization of the airway.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
PULSE OXIMETRY: apply and monitor**.**		X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
CONSCIOUS PATIENT - ABLE TO SPEAK, COUGH OR CRY					
REASSURE PATIENT: encourage coughing.	X	X	X	X	
SUCTION: as needed to control secretions.	X	X	X	X	
CONSCIOUS PATIENT - UNABLE TO SPEAK, COUGH, OR CRY					
BACK BLOWS & CHEST THRUSTS: for patients < 1 year of age. Alternate back blows and chest thrusts with head inferior to chest.	X	X	X	X	
ABDOMINAL THRUSTS: for patients > 1 year of age.	X	X	X	X	
REASSESS: repeat basic airway maneuvers until obstruction is cleared or the patient becomes unconscious.	X	X	X	X	
UNCONSCIOUS PATIENT					
VISUALIZE AIRWAY: use laryngoscope and pediatric Magill Forceps. May finger sweep only if obstruction visible. Reassess airway prior to ventilation after each CPR cycle.				X	
CHEST THRUSTS/HP-CPR: 15:2 ratio, even if pulses are present.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	

	F	E	O	P	D
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77 lbs). • Quicktrach device for patients > 35 kg (> 77 lbs). • 14 – 18G catheter for patients < 10kg (< 22 lbs). • Ventilate with high flow oxygen.				X	
	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
CONSCIOUS PATIENT - ABLE TO SPEAK, COUGH OR CRY					
REASSURE PATIENT: encourage coughing.	X	X	X	X	
SUCTION: as needed to control secretions.	X	X	X	X	
CONSCIOUS PATIENT - UNABLE TO SPEAK, COUGH, OR CRY					
BACK BLOWS & CHEST THRUSTS: for patients < 1 year of age. Alternate back blows and chest thrusts with head inferior to chest.	X	X	X	X	
ABDOMINAL THRUSTS: for patients > 1 year of age.	X	X	X	X	
REASSESS: repeat basic airway maneuvers until obstruction is cleared or the patient becomes unconscious.	X	X	X	X	
UNCONSCIOUS PATIENT					
VISUALIZE AIRWAY: use laryngoscope and pediatric Magill Forceps. May finger sweep only if obstruction visible. Reassess airway prior to ventilation after each CPR cycle.				X	
CHEST THRUSTS/HP-CPR: 15:2 ratio, even if pulses are present.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77 lbs). • Quicktrach device for patients > 35 kg (> 77 lbs). • 14 – 18G catheter for patients < 10kg (< 22 lbs). • Ventilate with high flow oxygen.				X	
	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
CONSCIOUS PATIENT - ABLE TO SPEAK, COUGH OR CRY					
REASSURE PATIENT: encourage coughing.	X	X	X	X	
SUCTION: as needed to control secretions.	X	X	X	X	
CONSCIOUS PATIENT - UNABLE TO SPEAK, COUGH, OR CRY					
BACK BLOWS & CHEST THRUSTS: for patients < 1 year of age. Alternate back blows and chest thrusts with head inferior to chest.	X	X	X	X	
ABDOMINAL THRUSTS: for patients > 1 year of age.	X	X	X	X	

	F	E	O	P	D
REASSESS: repeat basic airway maneuvers until obstruction is cleared or the patient becomes unconscious.	X	X	X	X	
UNCONSCIOUS PATIENT					
VISUALIZE AIRWAY: use laryngoscope and pediatric Magill Forceps. May finger sweep only if obstruction visible. Reassess airway prior to ventilation after each CPR cycle.				X	
CHEST THRUSTS/HP-CPR: 15:2 ratio, even if pulses are present.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77 lbs). • Quicktrach device for patients > 35 kg (> 77 lbs). • 14 – 18G catheter for patients < 10kg (< 22 lbs). • Ventilate with high flow oxygen.				X	
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC).	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
CONSCIOUS PATIENT - ABLE TO SPEAK, COUGH OR CRY					
REASSURE PATIENT: encourage coughing.	X	X	X	X	
SUCTION: as needed to control secretions.	X	X	X	X	
CONSCIOUS PATIENT - UNABLE TO SPEAK, COUGH, OR CRY					
BACK BLOWS & CHEST THRUSTS: for patients < 1 year of age. Alternate back blows and chest thrusts with head inferior to chest.	X	X	X	X	
ABDOMINAL THRUSTS: for patients > 1 year of age.	X	X	X	X	
REASSESS: repeat basic airway maneuvers until obstruction is cleared or the patient becomes unconscious.	X	X	X	X	
UNCONSCIOUS PATIENT					
VISUALIZE AIRWAY: use laryngoscope and pediatric Magill Forceps. May finger sweep only if obstruction visible. Reassess airway prior to ventilation after each CPR cycle.				X	
CHEST THRUSTS/HP-CPR: 15:2 ratio, even if pulses are present.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77 lbs). • Quicktrach device for patients > 35 kg (> 77 lbs). • 14 – 18G catheter for patients < 10kg (< 22 lbs). • Ventilate with high flow oxygen.				X	

Refer to 555.23 PEDIATRIC RESPIRATORY DISTRESS.

NOTE: Transport patient immediately to the closest receiving hospital if unable to clear obstruction or otherwise establish an airway. All patients should be transported to a receiving hospital regardless of airway maneuvers.

POLICY: 555.22
TITLE: Pediatric Respiratory Arrest

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC RESPIRATORY ARREST

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
POSITION AIRWAY: observe for return of spontaneous respiration.	X	X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.					
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA in place.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
D10: 2 – 4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
CONSIDER					
AIRWAY OBSTRUCTION: Refer to 555.21 PREDIATRIC AIRWAY OBSTRUCTION BY FOREIGN BODY.	X	X	X	X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.1 mg/kg IN/IM/IV/IO if mental status & respiratory effort are depressed & the child is not a newborn & there is a suspicion of opioid overdose. Maximum single dose 2 mg. Repeat every 5 minutes if indicated.				X	

POLICY: 555.23
TITLE: Pediatric Respiratory Distress

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC RESPIRATORY DISTRESS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Epiglottitis: History of mild upper respiratory infection. Usually occurs in patients age 3 to 6, but 25% of all cases occur in children less than 2 years of age. Signs & Symptoms: high fever, sore throat, pain on swallowing, shallow breathing, dyspnea, inspiratory stridor, drooling and a red swollen epiglottis. Hx: Lack of immunizations.
Asthma: Patient or family history of asthma or reactive airway disease. Signs & Symptoms: patient age > 1 year, tachypneic with the patient sitting up and leaning forward, unproductive cough, accessory respiratory muscle usage and wheezing (wheezing may not be present if the patient has insufficient air movement).
Bronchiolitis: Signs & Symptoms: patient age < 1 year, prominent expiratory wheezing and rales.
Croup: Occurs mostly at night during the fall and winter months. History: Mild cold or other infection. Signs & Symptoms: Patient age usually between 6 months and 4 years, harsh - barking cough, inspiratory stridor, nasal flaring and tracheal tugging.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT: look for signs of poor perfusion or respiratory distress (delayed capillary refill, diminished distal pulses, cool extremities, ALOC). Observe respirations and auscultate the lungs. **DO NOT VISUALIZE THE AIRWAY OR EXAMINE THE OROPHARYNX.**	X	X	X	X	
AIRWAY: support ventilations as indicated.	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
POSITION: place patient in position of comfort, usually in parent lap or arms.	X	X	X	X	

EPIGLOTTITIS					
POSITION: • Minimize handling and examination to prevent crying and agitation. • **Avoid laying the patient** down to prevent the epiglottis from falling and completely obstructing the airway.	X	X	X	X	

	F	E	O	P	D
EPIGLOTTITIS - COMPLETE OBSTRUCTION					
VENTILATE: 100% oxygen via bag-valve mask. Attempt high pressure ventilation if unable to ventilate via bag-valve mask.	X	X	X	X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77 lbs). • Quicktrach device for patients > 35 kg (> 77 lbs). • 14 – 18G catheter for patients < 10kg (< 22 lbs). • Ventilate with high flow oxygen.				X	
CAPNOGRAPHY: apply and monitor.				X	
ASTHMA - BRONCHIOLITIS					
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists (consider availability or need to reduce aerosol-generating procedure to decide). • **ALBUTEROL:** 2.5 mg via nebulizer for wheezing patients. If patient has SGA placed, administer through aerosol holding chamber of SGA. • **LEVALBUTEROL**: 1.25 mg via nebulizer.				X	
IPRATROPRIUM: via nebulizer, 250 mcg if < 20 kg or 500 mcg if ≥ 20 kg.				X	
MAGNESIUM SULFATE: 50 mg/kg IV/IO in children > 4 years old.				X	
CROUP					
NEBULIZER: 3 mL NS for croup patients.				X	
BASE CONTACT: contact base for orders of epinephrine nebulizer.					X
CONSIDER	F	E	O	P	D
EPINEPHRINE: 0.01 mg/kg of 1:1000 (1 mg/mL) IM for asthma if patient is not a neonate (max. single dose 0.5 mg). May repeat once for asthma patients.				X	
EPINEPHRINE – draw-up • < 30 kg administer 0.15 mg of 1:1000 (1 mg/mL) IM. • > 30 kg administer 0.3 mg of 1:1,000 (1 mg/mL) IM. For all weights repeat dose may be given every 5-15 minutes as needed for respiratory distress or persistent wheezing.			X	X	
EPINEPHRINE: auto-injector • < 30 kg administer 0.15 mg of 1:1000 (1 mg/mL) IM. • > 30 kg administer 0.3 mg of 1:1,000 (1 mg/mL) IM. For all weights repeat dose may be given every 5-15 minutes as needed for respiratory distress or persistent wheezing.		X	X	X	

Note: Parent should accompany the child to ease the child's fears and apprehension.

POLICY: 555.31
TITLE: Pediatric Altered Level of Consciousness

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Characterized by a Glasgow coma score of < 15, mental confusion, unresponsive.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider if conscious with an intact gag reflex, if blood sugar < 70 mg/dL.		X	X	X	
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	

	F	E	O	P	D
CONSIDER					
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.1 mg/kg IN/IM/IV/IO if mental status and respiratory effort are depressed and the child is not a newborn and there is a suspicion of opioid overdose. Maximum single dose 2 mg. Repeat every 5 minutes if indicated.			X	X	
CONSIDER CAUSES					
555.41 PEDIATRIC NON-TRAUMATIC SHOCK and 555.82 PEDIATRIC TRAUMA AND TRAUMATIC SHOCK 555.51 PEDIATRIC POISONING 555.53 PEDIATRIC OVERDOSE Head Trauma – refer to 555.82 PEDIATRIC TRAUMA AND TRAUMATIC SHOCK					

POLICY: 555.32
TITLE: Pediatric Status Seizure

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC STATUS SEIZURE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
An actively seizing child who has been seizing for more than ten minutes OR an actively seizing child with recurrent seizures with no reawakening between seizures.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
POSITION: gently support head of child to avoid injury. Loosen tight fitting clothing.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
MIDAZOLAM: Do not delay for IV/IO access. • IM/IN: 0.2 mg/kg up to 10 mg. May repeat if seizure continues every 5 minutes, max total dose 20 mg. • IV/IO: 0.1 mg/kg up to 5 mg every 2 minutes until seizure stops or max total dose 10 mg.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
TEST FOR GLUCOSE		X	X	X	
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10-minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	

	F	E	O	P	D
CONSIDER					
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.1 mg/kg IN/IV/IO/IM if mental status and respiratory effort are depressed and the child is not a newborn and there is a suspicion of opioid overdose. Maximum single dose 2 mg. Repeat every 5 minutes if indicated.				X	
CONSIDER CAUSES					
555.41 PEDIATRIC NON-TRAUMATUC SHOCK and 555.82 PEDIATRIC TRAUMA AND TRAUMATIC SHOCK 555.51 PEDIATRIC POISONING 555.53 PEDIATRIC OVERDOSE Head Trauma – refer to 555.82 PEDIATRIC TRAUMA AND TRAUMATIC SHOCK					

POLICY: 555.33
TITLE: Pediatric Behavioral Emergency

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC BEHAVIORAL EMERGENCY

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
The vast majority of patients are not violent, requiring only supportive care & transport. Responder & patient safety are paramount, especially when treating an aggressive or violent patient. **Restraints are to be used only to prevent injury & assure safety of the patient and/or responders.** EMS personnel shall make every effort to preserve the patient's health, safety, dignity, rights, & well-being.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SCENE SAFETY	X	X	X	X	
ASSESSMENT	X	X	X	X	
VERBAL DE-ESCALATION: if possible. Use non-judgmental terminology, speak in a calm voice, and avoid direct eye contact.	X	X	X	X	
***APPROVED PHYSICAL RESTRAINTS:** assure restraints do not compromise respirations, circulation, and neurological function. **Reassess & document distal neurovascular status every 15 minutes.**	X	X	X	X	
***CHEMICAL RESTRAINT:** 0.1 mg/kg midazolam IV/IO/IM/IN. May be done prior to or in conjunction with approved physical restraints. May repeat every 5 – 10 minutes if systolic BP ≥ 100 and respiratory rate ≥ 12. **DO NOT USE FOR PATIENTS YOUNGER THAN 12 YEARS OLD.**				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if chemical restraint administered.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	

*** 580.00 USE OF PATIENT RESTRAINTS**

The following forms of restraint shall **NOT** be used by prehospital personnel:

1. Hard plastic ties or any restraint device requiring a key to remove with the exception of restraints applied by law enforcement.
2. Sandwiching patient between backboards, scoop-stretchers, or flat.
3. Restraining both a patient's hands and feet behind the patient, i.e., hog-tying.
4. Methods or other materials applied in a manner that could cause respiratory, vascular, or neurological compromise, including prone restraints.

Restraints applied by law enforcement require the officer's continued presence to ensure patient and prehospital personnel safety. The officer should accompany the patient in the ambulance or follow the ambulance.

POLICY: 555.41
TITLE: Pediatric Non-Traumatic Shock

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC NON-TRAUMATIC SHOCK

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
History may include: GI bleeding, vomiting, diarrhea, allergic reaction, and septicemia.

Physical signs: collapsed peripheral/neck veins, confusion, cyanosis, thready pulse pale/cold/clammy/mottled skin, rapid respirations, anxiety.

NOTE: DECREASED BLOOD PRESSURE IS A LATE SIGN OF SHOCK.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor**.**		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: 100% by non-rebreather mask or blow-by.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider if conscious with an intact gag reflex and if blood sugar < 70 mg/dL.		X	X	X	
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose and repeat as indicated.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	

	F	E	O	P	D
CONSIDER					
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with "epi" and the calculated concentration in mcg/mL • Give 1 mL (1 mcg/kg) every 1 – 2 minutes and titrate to age appropriate SBP.				X	
EPINEPHRINE DRIP: To treat hypotension refractory to fluid. 0.1-1 mcg/kg/min mix 1 mg of Epi 1:1,000 (1 mg/mL) in 250mL. Titrate to age-appropriate BP. **Monitor IV/IO site q 5 minute for extravasation.** • 2mcg/min drip = 30 gtt/min (mL/hr) • 3mcg/min drip = 45 gtt/min (mL/hr) • 4mcg/min drip = 60 gtt/min (mL/hr) • 5mcg/min drip = 75 gtt/min (mL/hr) • 6mcg/min drip = 90 gtt/min (mL/hr) • 7mcg/min drip =105 gtt/min (mL/hr) • 8mcg/min drip=120 gtt/min (mL/hr) • 9mcg/min drip=135 gtt/min (mL/hr) • 10mcg/min drip=150 gtt/min (mL/hr)				X	

Consider Causes:

- Cardiogenic, Distributive or Hypovolemic Shock - IV fluid boluses
- Hypoxia - hyperventilate
- Anaphylaxis - refer to 555.42 PEDIATRIC ALLERGIC REACTION ANAPHYLAXIS
- 555.51 PEDIATRIC POISONING
- 555.53 PEDIATRIC OVERDOSE

Pediatric Normal Vital Signs

Age	HR	RR	BP	Temp (C)	Temp (F)
Premie	120-170	40-70	55-75/35-45	36-38	96.8-100.4
0-3 months	100-160	35-60	65-85/45-55	36-38	96.8-100.4
3-6 months	90-120	30-45	70-90/50-65	36-38	96.8-100.4
6-12 months	80-120	25-40	80-100/55-65	36-38	96.8-100.4
1-3 years	70-110	20-30	90-105/55-70	36-38	96.8-100.4
3-6 years	65-110	20-25	90-110/60-75	36-38	96.8-100.4
6-12 years	65-100	14-22	90-120/60-75	36-38	96.8-100.4
12+	55-100	12-20	100-135/65-85	36-38	96.8-100.4

POLICY: 555.42
TITLE: Pediatric Allergic Reaction - Anaphylaxis

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ALLERGIC REACTION - ANAPHYLAXIS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
REMOVE ALLERGEN: (i.e., bee stinger) & apply ice to site if indicated.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated. Consider second IV/IO access.				X	
FLUID BOLUS: 20 mL/kg fluid boluses for hypoperfusion.					
MILD or MODERATE REACTION (rash, swelling, wheezing)					
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists (consider availability or need to reduce aerosol-generating procedure to decide). • **ALBUTEROL:** 2.5 mg via nebulizer for wheezing patients. If patient has SGA placed, administer through aerosol holding chamber of SGA. • **LEVALBUTEROL**: 1.25 mg via nebulizer.				X	
IPRATROPRIUM: via nebulizer, 250 mcg if < 20 kg or 500mcg if > = 20 kg.				X	

	F	E	O	P	D
EPINEPHRINE: • < 30 kg administer 0.15 mg of 1:1000 (1 mg/mL) IM. • > 30 kg administer 0.3 mg of 1:1,000 (1 mg/mL) IM. For all weights repeat dose may be given every 5-15 minutes as needed for respiratory distress or persistent wheezing.			X	X	
EPINEPHRINE: auto-injector • < 30 kg administer 0.15 mg of 1:1000 (1 mg/mL) IM. • > 30 kg administer 0.3 mg of 1:1,000 (1 mg/mL) IM. For all weights repeat dose may be given every 5-15 minutes as needed for respiratory distress or persistent wheezing.		X			
DIPHENHYDRAMINE: 1 mg/kg IV/IO/IM with a maximum dose of 50 mg.				X	
SEVERE REACTION (hypotension, severe respiratory depression, oral swelling, altered mental status, chest tightness)					
EPINEPHRINE: 0.01 mg/kg of 1:10,000 (0.1 mg/mL) IV/IO with a maximum single dose of 0.1 mg. Repeat every 5 minutes as needed for respiratory distress and poor perfusion. If no IV/IO access, administer 0.01 mg/kg of 1:1,000 IM with a maximum single dose of 0.5 mg.)				X	
DIPHENHYDRAMINE: 1 mg/kg IV/IO/IM with a maximum dose of 50 mg.				X	
APPROVED BETA-2 AGONIST: choose **ONE** of the following beta-2 agonists (consider availability or need to reduce aerosol-generating procedure to decide). • **ALBUTEROL:** 2.5 mg via nebulizer for wheezing patients. If patient has SGA placed, administer through aerosol holding chamber of SGA. • **LEVALBUTEROL**: 1.25 mg via nebulizer.				X	
SEVERE REACTION (Cont.)	F	E	O	P	D
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77lbs). • Quicktrach device for patients > 35 kg (> 77lbs). • 14 – 18G catheter for patients < 10kg (< 22lbs). • Ventilate with high flow oxygen.				X	
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with “epi” and the calculated concentration in mcg/mL • Give 1 mL (1mcg/kg) every 1-2 minutes and titrate to age appropriate SBP.				X	
EPINEPHRINE DRIP: to treat hypotension refractory to fluid. 0.1-1 mcg/kg/min. Mix 1 mg of Epi 1:1,000 in 250 mL. **Monitor IV/IO site q 5 minute for extravasation.** • 2mcg/min drip = 30 gtt/min (mL/hr) • 3mcg/min drip = 45 gtt/min (mL/hr) • 4mcg/min drip = 60 gtt/min (mL/hr) • 5mcg/min drip = 75 gtt/min (ML/hr) • 6mcg/min drip = 90 gtt/min (mL/hr) • 7mcg/min drip =105 gtt/min (mL/hr) • 8mcg/min drip=120 gtt/min (mL/hr) • 9mcg/min drip=135 gtt/min (mL/hr) • 10mcg/min drip=150 gtt/min (mL/hr)					X

Pediatric Normal Vital Signs

Age	HR	RR	BP	Temp (C)	Temp (F)
Premie	120-170	40-70	55-75/35-45	36-38	96.8-100.4
0-3 months	100-160	35-60	65-85/45-55	36-38	96.8-100.4
3-6 months	90-120	30-45	70-90/50-65	36-38	96.8-100.4
6-12 months	80-120	25-40	80-100/55-65	36-38	96.8-100.4
1-3 years	70-110	20-30	90-105/55-70	36-38	96.8-100.4
3-6 years	65-110	20-25	90-110/60-75	36-38	96.8-100.4
6-12 years	65-100	14-22	90-120/60-75	36-38	96.8-100.4
12+	55-100	12-20	100-135/65-85	36-38	96.8-100.4

POLICY: 555.43
TITLE: Pediatric Pain Management

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC PAIN MANAGEMENT

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
The patient's severity of pain must be properly assessed in order to provide appropriate relief. This protocol is not intended to totally alleviate pain, but to safely decrease the intensity of the pain without causing physiologic compromise, delaying transport to definitive care or interfering with the patient's diagnostic work up following arrival at the emergency department.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
PAIN TREATMENT (NON-CARDIAC): consider non-pharmaceutical options – position of comfort, splint, ice, elevate as indicated.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
PHARMACEUTICAL PAIN TREATMENT: Choose most appropriate pharmaceutical intervention below. Consider non-opioid interventions first.				X	
ACETAMINOPHEN: 15 mg/kg, oral suspension or IV infusion. IV infusion administer over 15 minutes. Max dose 1000 mg. No repeat dose.				X	
KETOROLAC: For abdominal, back or extremity pain, 0.5 mg/kg, up to 15 mg over 15 seconds, IN/IM/IV/IO. **Ketorolac is not to be used in patients under 2y.**				X	
***MORPHINE:** 0.1 mg/kg IM or slow IV/IO up to 10 mg for severe pain. May repeat dose every 10-15 minutes up to 0.3 mg/kg max total dose.				X	

	F	E	O	P	D
†**FENTANYL:** 1-2 mcg/kg IV/IO/IN/IM. May repeat in 10 minutes at 0.5 mcg/kg, up 3mcg/kg maximum total dose. To be used with caution in patients taking narcotics, benzodiazepines**,** MAOIs, conivaptan, crizotinib, linezolid, nalbuphine, pazopanib, pentazocine, sibutramine, sodium oxybate, rifampin/ isoniazid.				X	
MIDAZOLAM: 0.1 mg/kg IM/IN or slow IV/IO, maximum single dose of 2 mg. • IV/IO: repeat every 5 minutes • IM/IN: repeat every 10 minutes • Repeat doses up to a maximum total of 5 mg IF THE PATIENT IS OBESE, DOSAGES SHOULD BE CALCULATED ON THE PATIENTS' IDEAL WEIGHT.				X	

*** † USE WITH CAUTION IN PATIENTS WITH:**

- Head trauma
- Decreased respirations
- Altered Mental Status
- Blood pressure < 90mmhg systolic
- Patients with ETOH intoxication

*** † OBSERVE FOR**

- Respiratory depression
- Vomiting
- Hypotension
- Slurred Speech
- Allergic Reaction

AVOID THE USE OF MORPHINE AND FENTANYL CONCURRENTLY: If a patient experiences an adverse effect from one of these medications, the patient is experiencing unrelenting severe pain, and the transport time is extended, changing to the alternate medication may be appropriate with Base Hospital Physician consultation.

ANYTIME BOTH MORPHINE & FENTANYL IS ADMINISTERED TO A SINGLE PATIENT, AN UNUSUAL OCCURRENCE REPORT IS TO BE SUBMITTED TO THE EMS AGENCY

POLICY: 555.44
TITLE: Pediatric Sepsis

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC SEPSIS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Sepsis is a potentially lethal medical condition that is characterized by a whole-body inflammatory state called Systemic Inflammatory Response Syndrome (SIRS). The immune system develops this inflammatory response to microbes in the blood, urine, lungs, skin, or other tissues. The syndrome can include fever, tachycardia, tachypnea, and hypotension.

Sepsis is more common in the elderly, newborns, diabetics, and persons with a compromised immune system. Other risk factors include cancer, renal disease, alcohol/drug abuse, malnutrition, hypothermia, recent surgery or invasive procedure.

Patient should be presumed to be septic if the patient meets two or more of the following criteria with no other identifiable cause:

1. Poor perfusion (capillary refill delayed 2+ seconds)
2. Tachycardia out of proportion to fever or unexplained tachycardia
3. Tachypnea out of proportion to fever
4. Hypotension = decompensated shock
5. ET CO2 < 25 can indicate sepsis
6. Suspected infection

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor		X	X	X	
OXYGEN: if pulse oximetry < 94% or signs respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
SEPSIS ALERT: if sepsis criteria met		X	X	X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
FLUID BOLUS: NS 20 mL/kg rapid bolus. Repeat once for hypotension. Reassess lungs after every bolus.				X	

	F	E	O	P	D
ACETAMINOPHEN: 15 mg/kg IV/PO. Max single dose 1000 mg. Withhold if given in the last 4 hours.				X	
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with "epi" and the calculated concentration in mcg/mL • Give 1 mL (1mcg/kg) every 1-2 minutes (1 mcg/kg) and titrate to age appropriate SBP				X	
GLUCOSE MEASUREMENT		X	X	X	
ORAL GLUCOSE: consider if conscious with an intact gag reflex and if blood sugar < 70 mg/dL.		X	X	X	
D10: 2 – 4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	

Pediatric Normal Vital Signs

Age	HR	RR	BP	Temp (C)	Temp (F)
Premie	120-170	40-70	55-75/35-45	36-38	96.8-100.4
0-3 months	100-160	35-60	65-85/45-55	36-38	96.8-100.4
3-6 months	90-120	30-45	70-90/50-65	36-38	96.8-100.4
6-12 months	80-120	25-40	80-100/55-65	36-38	96.8-100.4
1-3 years	70-110	20-30	90-105/55-70	36-38	96.8-100.4
3-6 years	65-110	20-25	90-110/60-75	36-38	96.8-100.4
6-12 years	65-100	14-22	90-120/60-75	36-38	96.8-100.4
12+	55-100	12-20	100-135/65-85	36-38	96.8-100.4

POLICY: 555.45
TITLE: Pediatric Nausea

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC NAUSEA

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed				X	
OXYGEN: If pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MON ITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated				X	
***ONDANSETRON:** 0.15 mg/kg up to a maximum of 4 mg for a child older than 6 months IM/IV/IO or 4 mg Oral Disintegrating Tablet (ODT) for a child over 26 kg.				X	
****DIPHENHYDRAMINE:** • Age 2-5 years 6.25 mg slow IV or IM. May repeat to a maximum of 12.5 mg. • Age 6-12 years 12.5 mg slow IV or IM. May repeat to a maximum of 25 mg.				X	

***PRECAUTIONS FOR ONDANSETRON:**
Do not use under 6 (six) months of age.
• Known Sensitivity to Ondansetron (Zofran) or other 5-HT-3 antagonists.
- Granisetron (Kytril)
- Dolasetron (Anzemet)
- Palonosetron (Aloxi)

**** PRECAUTIONS FOR DIPHENHYDRAMINE:**

Do not use under two (2) years of age.

- **USE WITH CAUTION IN PATIENTS WITH:**
  - Barbiturates, opiates, hypnotics, tricyclic antidepressants, MAOIs & alcohol.
  - CNS depression
  - Asthma
- **WATCH CLOSELY FOR:**
  - Mouth dryness
  - Respiratory depression
  - Vomiting
  - Hypotension
  - Slurred speech
  - Allergic reaction

POLICY: 555.51
TITLE: Pediatric Poisoning

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC POISONING

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Includes: Caustic Corrosives (alkalis, acids, oxidizers), Petroleum Distillates, and Organophosphates.

In the event of a release of nerve agents or organophosphates, notify dispatch to request the MHOAC order CHEMPACK.

NOTE: DO NOT INDUCE VOMITING

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

ALL POISONINGS	F	E	O	P	D
PROTECT FROM CONTAMINATION	X	X	X	X	
DECONTAMINATION: • Remove contaminated clothing. • If agent is dry, brush off. If agent is liquid, flush copiously with water. • If the eyes are contaminated flush with saline for at least 20 minutes.	X	X	X	X	
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilation with appropriate airway adjuncts. Observe for airway burns.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
***OXYGEN**: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
ONDANSETRON: 0.15 mg/kg up to a maximum of 4 mg IM/IO/IV for a child over 6 months of age, or 4 mg Oral Disintegrating Tablet (ODT) for a child over 26 kg.				X	

	F	E	O	P	D
CARBON MONOXIDE					
OXYGEN: 15 – LPM via non-rebreather or BVM.	X	X	X	X	
ORGANOPHOSPHATES					
ATROPINE: 0.05 mg/kg increments slow IV/IO/IM. Repeat every 5 minutes as needed to control secretions, bradycardia, bronchorrhea, and dysrhythmia.				X	
MIDAZOLAM: Do not delay for IV/IO access. • IM/IN: 0.2 mg/kg up to 10 mg every 5 minutes until seizure stops, max total dose 20 mg. • IV/IO: 0.1 mg/kg up to 5 mg every 2 minutes until seizure stops or max total dose 10 mg.				X	
NASOGASTRIC TUBE: suction gastric contents – only if patient has SGA and oral ingestion has occurred within 60 minutes.				X	
PETROLEUM DISTILLATES					
NASOGASTRIC TUBE: suction gastric contents – only if patient has SGA and oral ingestion has occurred within 60 minutes. **For PO Ingestion Only.**					X

*** Use oxygen with caution near any hazardous materials**

CARBON MONOXIDE

- Carbon monoxide is an odorless, colorless, tasteless toxic gas. Carbon monoxide poisoning is easily misdiagnosed as flu-like symptoms, fatigue, or other general complaints. Common sources of carbon monoxide include motor vehicles, structure and wildland fires, gas-powered machines operating in closed spaces, improperly functioning wood-burning stoves, heaters, or furnaces, and industrial sites. Untreated carbon monoxide may result in short and long-term health consequences.
- Refer to BURNS P80 and TRAUMA and TRAUMATIC SHOCK A82 as indicated,

CAUSTIC CORROSIVES

- **Alkalis:** sodium hydroxide (caustic soda), drain cleaners, potassium hydroxide, ammonium hydroxide (fertilizers), lithium hydroxide (photographic chemicals, alkaline batteries), calcium hydroxide (lime).
- **Acids:** hydrofluoric acid (which may have a delayed onset of symptoms), sulfuric acid (battery acid), hydrochloric acid.
- **Oxidizers:** bleach, potassium permanganate.
- Refer to 555.81 PEDIATRIC BURNS and 555.82 PEDIATRIC TRAUMA AND TRAUMATIC SHOCK as indicated.

ORGANOPHOSPHATE

- May cause bronchospasm, an increase in pulmonary and nasal secretions, constricted pupils, vomiting, diarrhea, urinary incontinence, diaphoresis, and cardiac dysrhythmias including both bradycardia and AV blocks.
- Remember the most spectacular signs by the following mnemonic: (**S**alivation, **L**acrimation, **U**rination, **D**efecation, **G**astric upset, **E**mesis and **M**iosis - **SLUDGEM**.)
- Other useful mnemonics are, "**MUDDLES**:" **M**iosis, **U**rination, **D**efecation, **D**iaphoresis, **L**acrimation, **E**mesis, **S**alivation; and "**DUMBBELS"**: **D**iarrhea, **U**rination, **M**iosis/muscle weakness, **B**ronchorrhea, **B**radycardia, **E**mesis, **L**acrimation, **S**alivation/sweating.

POLICY: 555.52
TITLE: Pediatric Dystonic Reactions to Phenothiazines

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC DYSTONIC REACTIONS TO PHENOTHIAZINES

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
DIPHENHYDRAMINE: 1 mg/kg IV/IO push titrated to relief of signs and symptoms or IM if IV/IO access not promptly available. Max dose 50 mg.				X	
ACTIVATED CHARCOAL: 1 g/kg, maximum 50 g PO if patient's GCS is 15 or via NG if patient is intubated and oral ingestion has occurred with 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	
NASOGASTRIC TUBE: suction gastric contents only if patient has SGA and oral ingestion has occurred with 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	

NOTE: Phenothiazine reactions may occur at normal dosing levels and the induction of vomiting is not recommended.

POLICY: 555.53
TITLE: Pediatric Overdose

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC OVERDOSE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

NOTE: DO NOT INDUCE VOMITING

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: defer SGA until after naloxone administration then consider if GCS < 8 and not rapidly improving.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
***VASCULAR ACCESS:** IV/IO, rate as indicated.				X	
ACTIVATED CHARCOAL: 1 g/kg, maximum 50 g po if patient's GCS is 15 or via NG only if patient is intubated and oral ingestion has occurred within 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	
NASOGASTRIC TUBE: suction gastric contents only if patient is intubated and oral ingestion has occurred with 60 minutes. **(FOR OVERDOSE VIA INGESTION ONLY).**				X	
TRICYCLIC ANTIDEPRESSANTS					
SODIUM BICARBONATE - 1 mEq/kg slow IV push for cardiac dysrhythmia or QRS complex wider than 0.10 seconds. Repeat as necessary. • 0-2 yo: dilute to 4.2% concentration by 1:1 with sterile water. Label syringe 4.2% Sodium Bicarbonate.				X	

	F	E	O	P	D
****MIDAZOLAM:** for Status Seizures. Do not delay for IV/IO access. • IM/IN: 0.2 mg/kg up to 10 mg. May repeat if seizure continues every 5 minutes, max total dose 20 mg. • IV/IO: 0.1 mg/kg up to 5 mg every 2 minutes until seizure stops or max total dose 10 mg.				X	
NARCOTICS – SEDATIVES					
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2 – 3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	
NALOXONE: 0.1 mg/kg IV/IO/IM/IN for respiratory depression if opioid overdose is suspected. Max single dose 2 mg. May repeat every 5 minutes, to a total maximum 12 mg.				X	

***Administer fluid boluses with caution due to the high incidence of pulmonary edema in tricyclic overdose patients.**

****Most tricyclic overdose seizures are short lived and do not require the administration midazolam.**
Tricyclic antidepressants include: Amitriptyline (Elavil, Endep, Emitrip, Enovil), Amoxapine (Asendin), Clomipramine (Anafranil), Desipramine (Norpramin, Pertofrane), Doxepin (Adapin, Sinequan), Imipramine (Janimine, Tipramine, Tofranil, Tofranil-PM), Maprotiline (Ludiomil), Nortriptyline (Pamelor, Aventyl), Protriptyline (Vivactil), Trimipramine (Surmontil)

POLICY: 555.61
TITLE: Pediatric Envenomation

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ENVENOMATION

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SCENE SAFETY	X	X	X	X	
ASSESSMENT	X	X	X	X	
IDENTIFY CAUSE: if feasible and safe to do so, have animal transported for identification purposes. • **Bee/Wasp sting:** Remove (scrape away) stinger. Cold packs may be applied to relieve pain. • **Spider bite/Scorpion sting:** Remove stinger. Cold packs may be applied to relieve pain. • **Snake envenomation:** Avoid movement of the affected extremity, keeping extremity at or below heart level. **DO NOT APPLY ICE**. Monitor distal pulses. Circle any swelling around bite marks with a pen and note time. Additionally, measure the circumference of the extremity proximal to the bite and note time. This measurement can be used as a baseline for determining the progress of swelling.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
IDENTIFY CAUSE: if feasible and safe to do so have the dead animal transported for identification purposes.	X	X	X	X	
MIDAZOLAM: if suspected Black Widow Spider bite and muscle spasms, refer to 555.43 PEDIATRIC PAIN MANAGEMENT.				X	

POLICY: 555.62
TITLE: Pediatric Hypothermia - Frostbite

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC HYPOTHERMIA - FROSTBITE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Patients with severe hypothermia may appear dead (absent pulse, respiration, and fixed pupils) but still have cardiac electrical activity.

USE EXTREME CAUTION WHEN MOVING PATIENT

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

Moderate Hypothermia (92°-95° F/ 33°-35° C) **Severe Hypothermia (Core temp < 92° F / < 33° C)**	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if patient's GCS is less than 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
WARMING MEASURES: remove wet clothing and cover with warm dry blankets. Use ambient heat and heat packs as able.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated with warm fluids.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider if conscious with an intact gag reflex if blood sugar < 70 mg/dL.		X	X	X	
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	

	F	E	O	P	D
FROSTBITE (skin is white, numb or burning, soft to touch and does not recolor with touch)					
WARMING MEASURES: move patient to warm environment and wrap affected extremity with thick, warmed blankets or clothing. **DO NOT RUB AFFECTED EXTREMITY AND AVOID CHEMICAL HEAT PACKS.**	X	X	X	X	
Refer to 555.43 PEDIATRIC PAIN MANAGEMENT as indicated.				X	

POLICY: 555.64
TITLE: Pediatric Heat Illness

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC HEAT ILLNESS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Heat Cramps/Exhaustion: Muscle cramping, dizziness, exhaustion, nausea, vomiting, weakness, headache, diaphoresis, normal or slightly elevated body temperature. Syncope and an altered level of consciousness may occur.

Heat Stroke: Altered level of consciousness and elevated core body temperature, usually > 104ºF (40ºC), often associated with tachycardia, hypotension, and absence of sweating.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

HEAT CRAMPS – HEAT EXHAUSTION	F	E	O	P	D
ASSESS	X	X	X	X	
COOLING MEASURES: move to cool location and start cooling as soon as possible.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO.				X	
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus. For heat stroke, use cooled IV fluids as available.				X	

	F	E	O	P	D
HEAT STROKE					
AS ABOVE AND ADDITIONALLY:					
COOLING MEASURES: In order of effectiveness, use dependent on availability of resources: 1. If on scene at an event where staff have initiated cold water immersion (CWI) for suspicion of heat stroke, do not move the patient from cold water immersion until patient starts shivering or 15-20 minutes of immersion, whichever is soonest. Ideal core temperature, if available, would be 102°F (39°C) or less when CWI is discontinued. 2. If CWI not available but cool/cold water is, remove clothing and rotate cool/cold wet towels over entire body of patient 3. If CWI and cool/cold wet towels not available, remove clothing, splash/sponge patient with water and place cool packs on neck, axillary, and inguinal areas. Promote evaporative cooling by fanning.	X	X	X	X	
TEST FOR GLUCOSE		X	X	X	
D10: 2 - 4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.					
MIDAZOLAM: for Status Seizures. Do not delay for IV/IO access. • IM/IN: 0.2 mg/kg up to 10 mg every 5 minutes until seizure stops, max total dose 20 mg. • IV/IO: 0.1 mg/kg up to 5 mg every 2 minutes until seizure stops or max total dose 10 mg.				X	

POLICY: 555.65
TITLE: Pediatric Non-Fatal Drowning

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC NON-FATAL DROWNING

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL
Drowning or near drowning patients may also have significant head, neck, and back injuries. Strongly consider spinal immobilization when a history of jumping or diving into the water exists, or the history is unclear.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SPINAL MOTION RESTRICTION: as indicated.	X	X	X	X	
ASSESSMENT	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
VASCULAR ACCESS: IV/IO, rate as indicated.				X	
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with “epi” and the calculated concentration in mcg/mL • Give 1 mL (1 mcg/kg) every 1 – 2 minutes and titrate to age appropriate SBP				X	
Refer to 555.62 PEDIATRIC HYPOTHERMIA - FROSTBITE as indicated.	X	X	X	X	

POLICY: 555.81
TITLE: Pediatric Burns

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC BURNS

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

TRANSPORT PER TRAUMA POLICIES

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
SCENE SAFETY: move patient to a safe environment.	X	X	X	X	
ASSESSMENT	X	X	X	X	
STOP THE BURING PROCESS: • **CHEMICAL BURNS**: brush off dry chemicals then flush with copious amounts of water. Consult container label for decontamination instructions and transport label with patient. • **TAR BURNS**: cool with water and transport. Do not attempt to remove tar. • **THERMAL BURNS**: cool with water for up to 5 minutes to stop the burning process. Avoid prolonged cool water usage due to risks of hypothermia and local cold injury.					
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
NEEDLE CRICOTHYROTOMY: if unable to ventilate with SGA • Quicktrach Child device for patients 10-35 kg (22-77lbs). • Quicktrach device for patients > 35 kg (> 77lbs). • 14 – 18G catheter for patients < 10kg (< 22lbs). • Ventilate with high flow oxygen.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if advanced airway has been placed.				X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.				X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	

	F	E	O	P	D
VASCULAR ACCESS: IV/IO.				X	
FLUID RESUSCITATION: partial thickness & full thickness burns: 0.5 mL x patient weight in kg x %TBSA burn = the amount of fluid to be administered in the first hour. Consider warm IV fluids, unless hyperthermic.				X	
DRESS BURNS: Cover thermal burns with dry dressing and keep patient warm.	X	X	X	X	
Refer to 555.43 PEDIATRIC PAIN MANAGEMENT.				X	

POLICY: 555.82
TITLE: Pediatric Trauma and Traumatic Shock

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC TRAUMA AND TRAUMATIC SHOCK

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
CONTROL OBVIOUS BLEEDING	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: if pulse oximetry < 94% signs of respiratory distress or hypoperfusion. High flow oxygen for traumatic shock and/or traumatic brain injury.	X	X	X	X	
SPINAL MOTION RESTRICTION: if indicated. **NOT** indicated for penetrating spinal trauma.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
WARM PATIENT: trauma patients are very susceptible to hypothermia, even in a warm environment.	X	X	X	X	
DRESS & SPLINT: as indicated.	X	X	X	X	
VASCULAR ACCESS: IV/IO, rate Attempt at least 2 large bore IVs.				X	
FLUID BOLUS: administer fluid boluses at a rate of 20 mL/kg, as indicated. Reassess after each bolus. If suspected uncontrolled bleeding, maintain systolic BP normal minimum for age. Use warm IV fluids.					
***TRANEXAMIC ACID:** 15 mg/kg to a max of 1 gm in 100 mL of NS infused IV/IO over 10 minutes.				X	
TEST FOR GLUCOSE		X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.		X	X	X	

	F	E	O	P	D
D10: 2-4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	
NEUROGENIC SHOCK					
PUSH DOSE EPINEPHRINE: • Draw up patient 0.01 mg/kg code dose 1:10,000 (0.1 mg/mL) epi • In same syringe, draw the necessary quantity of NS to total 10 mL • Label the syringe with "epi" and the calculated concentration in mcg/mL • Give 1 mL (1 mcg/kg) every 1-2 minutes and titrate to age appropriate SBP.				X	
HEAD – NECK – FACIAL TRAUMA					
POSITION: place head injured patients in reverse Trendelenburg (elevate the head 15-20°) if patient exhibits no signs of shock.	X	X	X	X	
CHEST TRAUMA					
NEEDLE THORACOSTOMY: for tension pneumothorax, on affected side(s) between 2nd & 3rd intercostal space midclavicular line **OR** between 4th & 5th intercostal space midaxillary line. Place catheter just above the rib to avoid intercostal artery. Repeat if suspected catheter occlusion. Perform on both sides if unable to isolate affected side.				X	
EXTREMITY TRAUMA					
HEMOSTATIC GAUZE: if hemorrhage is not controlled by basic intervention.		X	X	X	
TOURNIQUET: if hemorrhage is not controlled by basic intervention.	X	X	X	X	
DRESS & SPLINT • Splint dislocations in position found. • Return injured extremities (non-dislocations) to anatomic position as resistance and pain allows. • Check and document neurovascular status prior to & after each extremity manipulation. • Cover exposed bone with saline soaked gauze. Do not reduce exposed bone back into wound. • Grossly angulated long bone fractures may be reduced with gentle unidirectional traction for splinting.	X	X	X	X	
Continued from above	F	E	O	P	D
TRACTION SPLINT: for mid-shaft femur fracture. Check and document neurovascular status prior to and after each extremity manipulation.		X	X	X	
ALL TRAUMA PATIENTS					
TRANSPORT: per trauma triage protocol.	X	X	X	X	
PAIN MANAGEMENT: refer to 555.43 PEDIATRIC PAIN MANAGEMENT.				X	

* TXA should be administered to trauma patients who meet the following criteria, unless otherwise indicated:

1. Systolic BP of less than 90 mmHg.
2. Uncontrolled bleeding.
3. Time of injury < 3 hours.

CONSIDERATIONS:

NEUROGENIC SHOCK:

- Consider neurogenic shock when hypotensive, bradycardic, after possible spinal cord injury or TBI

HEAD – NECK – FACE:

- **Avulsed Tooth** - replace tooth in socket (if adult tooth and patient is conscious and alert) or place tooth in milk, normal saline, saline soaked gauze, or a commercially available "tooth saver."
- **Eye Injuries** - Stabilize or dress both eyes in place with saline soaked gauze or use cup or eye shield. Avoid applying direct pressure to eye and do not attempt to replace partially torn globe.
- **Impaled Object** - Immobilize and leave in place. Remove object only upon Base Physician order or if it interferes with CPR or if the object is impaled in the face, cheek, or neck and is compromising ventilation.

CHEST

- **Impaled Object:** Immobilize object and leave in place. Remove object only upon Base Physician order or if object interferes with CPR.
- **Flail Chest:** Stabilize chest. Observe for tension pneumothorax. Consider assisted ventilation.
- **Open Chest Wound:** Cover wound with occlusive dressing. If patient is being artificially ventilated, dress wound loosely (do not seal). Continuously reevaluate patient to watch for the development of a tension pneumothorax.
- **Cardiac Tamponade:** If the patient has a systolic BP < 90, administer 250 mL fluid boluses as indicated. Reassess the patient after each bolus.
- **Cardiac Contusion:** Monitor for dysrhythmia. Refer to Cardiac guidelines.

ABDOMINAL

- **Impaled Object** - Immobilize and leave in place. Remove object only upon Base Physician order or if object interferes with CPR.
- **Eviscerating Trauma** - Cover eviscerated bowels and organ with saline soaked gauze. **Do not attempt to replace bowels or organs into the abdominal cavity.**
- **Genital Injuries** - Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding.
    - Treat genital amputation the same as extremity amputation, refer to Extremity

EXTREMITY –

- **Amputations**: If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in saline soaked gauze, place in container or bag. Place container or bag in ice, if possible. **Do not place amputated part directly on ice.**
- TOURNIQUET APPLICATION
    - The tourniquet should be applied onto bare skin to prevent slipping.
    - Place the tourniquet as low on the limb as possible, above the wound and above the joint.
    - A 2nd tourniquet may be placed just above the first if bleeding is not controlled with a single tourniquet. If an extremity amputation, the 2nd tourniquet can be placed just above the wound.
    - The tourniquet is tightened with the aim of stopping a distal pulse.
    - The tourniquet is clearly marked including time and date of application.

POLICY: 555.83
TITLE: Pediatric Traumatic Arrest

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC TRAUMATIC ARREST

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. PROTOCOL

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic D = Base Hospital Physician Order Required

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
HP-CPR: including AED. Continue as appropriate. Do not delay transport even if CPR has to be interrupted.	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	
SUPRAGLOTTIC AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.				X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor if SGA has been placed.				X	
OXYGEN: ventilate with 100% oxygen.					
SPINAL MOTION RESTRICTION: if indicated.	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
DEFIBRILLATION: for V-fib or V-tach, defibrillate 1st time @ 2 joules/kg. Immediately restart CPR. Reassess rhythm every 2 minutes. Subsequent defibrillations @ 4 joules/kg. Complete TRAUMATIC ARREST P81 before referring to cardiac guidelines.				X	
TRANSPORT ASAP: immediate transport to closest definitive care.	X	X	X	X	
VASCULAR ACCESS: IV/IO, attempt at least 2 large bore IVs.				X	
FLUID BOLUS: NS 20 mL/kg as indicated. Reassess after each bolus. If suspected uncontrolled bleeding, maintain systolic BP normal for age.					
DRESS & SPLINT: as needed and as time allows.	X	X	X	X	
NEEDLE THORACOSTOMY - for tension pneumothorax, on affected side(s) between 2nd & 3rd intercostal space midclavicular line **OR** between 4th & 5th intercostal space midaxillary line. Place catheter just above the rib to avoid the intercostal artery. Repeat if suspected catheter occlusion. Perform on both sides if unable to isolate affected side.				X	

	F	E	O	P	D
TEST FOR GLUCOSE		X	X	X	
D10: 2 - 4 mL/kg IV/IO if blood sugar < 70 mg/dL for age > 28 days old or 2 mL/kg IV/IO if blood sugar < 40 mg/dL age ≤ 28 days old. Recheck blood glucose 10 minutes post infusion and repeat as needed.				X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 0.05 mg/kg IM (max 1 mg) if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 mg/dL, repeat dose.				X	
****TERMINATION OF RESUSCITATION:** if none of • NOT hypothermic, • NOT victim of submersion, • NOT obviously pregnant, • Reversible causes treated, • NO ROSC after 5 two-minute cycles of HP-CPR performed					X

** **Refer to Policy #570.20, DETERMINATION OF DEATH IN THE PREHOSPITAL SETTING**

Miscellaneous Policies

POLICY: 231.00
TITLE: Emergency Medical Technician Certification

EFFECTIVE: 12/12/2018
REVIEW: 12/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMERGENCY MEDICAL TECHNICIAN CERTIFICATION

I. AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 2 and Chapter 6;
Health & Safety Code Division 2.5;
California Government Code Section11507.6, 11507.7, 11513, 11514
California Government Code Division 4, Chapter 9.6 and 9.7 Section 3230 and 3300

II DEFINITIONS

A. "Agency" means the Mountain-Valley Emergency Medical Services Agency.

B. "Candidate" means an individual who is applying for certification as an EMT.

C. "Certification" means authorization to practice EMT skills in the State of California.

D. "Initial Certification" means certification of a candidate who has never held valid EMT certification in the State of California.

E. "Re-Certification" means applying for a re-issuance of Certification issued by the Agency.

F. "Lapsed Certification" means an individual whose certification has expired.

G. "Emergency Medical Technician or EMT" means an individual who has met all applicable certification requirements of this policy.

H. "Approved Training Program" means an EMT Training Program that has met all the requirements of California Code of Regulations Title 22, Division 9, Chapter 2 Article 3 and has been approved by an EMT Approving Authority as defined by Title 22 Division 9 Chapter 2 Section100057 of the California Code of Regulations.

III PURPOSE

The purpose of this policy is to provide a mechanism whereby individuals may certify or re-certify as an EMT; and to reference the procedures to be followed in cases of certificate revocation, suspension, probation, or denial.

IV. POLICY

The Agency shall issue EMT certification to those candidates who meet all certification requirements. The Agency shall follow Title 22, Division 9, Chapter 6, of the California Code of Regulations in cases of certificate denial, suspension, revocation, or probation.

V. PROCEDURE

A. All candidates for certification and re-certification shall:

1. Complete an application that includes:
   a. A copy of a current driver's license or a government issued identification card.
   b. A signed affidavit that the candidate is at least 18 years of age.

c. A signed affidavit that the candidate is not precluded from certification for reasons defined in Health and Safety Code, Section 1798.200.
d. Proof of completion of a California Department of Justice (DOJ) Background Check (if not previously on file with the Agency). If a Candidate's DOJ report is not received, the Candidate will be required to comply with any requests made by the Agency to reprocess their DOJ Background Check.
e. A copy of current CPR certification taught to the curriculum guidelines of the American Heart Association or American Red Cross at the Healthcare Provider level, or equivalent.
f. Verification of compliance with pre-hospital training standards required in Agency policy 853.00.

2. For Initial Certification:
   a. Verification of current certification from the National Registry of Emergency Medical Technicians as an EMT.
   b. A copy of current certification as an Advanced EMT or Paramedic licensed in the State of California, or
   c. Documentation of successful completion of an approved out-of-state initial EMT training course, within the last two years, which meets the requirements of Title 22, Division 9, Chapter 2 of the California Code of Regulations.

3. For Re-Certification:
   a. Documentation of successful completion of 24 hours of continuing education in accordance with California Code of Regulations Title 22, Division 9, Chapter 2, Section100080 and Agency Policy 237.00 (Continuing Education for Prehospital Personnel), AND
   b. A completed Agency approved Verification of Skills Form documenting competency to National Registry standards of the following skills:
      (1) Patient examination, trauma patient
      (2) Patient examination, medical patient
      (3) Airway emergencies (test on one only)
         (a) Mouth-To-Mask with Supplemental Oxygen
         (b) Upper Airway Adjuncts and Suction
      (4) Breathing emergencies (test on one only)
         (a) Supplemental Oxygen Administration
         (b) Bag-Valve-Mask Apneic Patient
      (5) Automated External Defibrillation
      (6) Circulation Emergency - Bleeding Control - Shock Management
      (7) Neurological emergencies (test on one only)
         (a) Spinal Immobilization - Seated patient
         (b) Spinal Immobilization - Supine patient
      (8) Penetrating Chest Injury
      (9) Epinephrine & Naloxone Administration
      (10) Obstetrical Emergency

4. Pay the appropriate certification fee.

B. Upon successful completion of all certification requirements, the candidate shall be issued Certification for a two (2) year period.

C. An individual with lapsed Certification may be recertified as an EMT as follows:
   1. For a lapse of less than six months, the individual shall comply with all items listed in Section V.A.1 and V.A.3 of this policy.

   2. For a lapse of six months or more, but less than twelve months, the individual shall comply with all items listed in Section V.A.1 and V.A.3 of this policy, AND complete an additional 12 hours of continuing education.

   3. For a lapse of twelve months or more, but less than twenty-four months, the individual shall comply with the requirements of Section V.A.1 and V.A.3 of this policy, AND complete an

additional 24 hours of continuing education, AND successfully complete the written National Registry examination.

4. For a lapse of more than 24 months, the candidate is required to successfully complete an entire EMT course and comply with all the requirements for Initial Certification.

5. Payment of late fees established by the Agency.

D. EMT Certification shall be denied, or an EMT Certification may be suspended or revoked if the candidate meets any of the following:
1. Has committed any sexually related offense specified under Section 290 of the Penal Code.
2. Has been convicted of murder, attempted murder, or murder for hire.
3. Has been convicted of two or more felonies.
4. Is on parole or probation for any felony.
5. Has been convicted and released from incarceration during the preceding fifteen years of the crime of manslaughter or involuntary manslaughter.
6. Has been convicted and released from incarceration during the preceding ten years for any offense punishable as a felony.
7. Has been convicted of two misdemeanors within the preceding five years for any offense relating to the use, sale, possession, or transportation off narcotics or addictive or dangerous drugs.
8. Has been convicted of two misdemeanors within the preceding five years for any offense relating to force, violence, threat, or intimidation.
9. Has been convicted within the preceding five years of any theft related misdemeanor.
10. Has committed any act within the preceding seven years involving fraud or intentional dishonesty for personal gain.

E. All disciplinary proceedings shall be conducted in accordance with Title 22, Division 9, Chapter 6, of the California Code of Regulations.

1. If the certificate holder is a firefighter who is alleged to have engaged in violation or omissions while on duty, investigation shall be conducted in accordance with the Firefighters Procedural Bill of Rights Act (California Government Code Section 3250 et. Seq.)

2. If the certificate holder is a public safety officer who is alleged to have engaged in violation or omissions while on duty, investigation shall be conducted in accordance with the Public Safety Officers Procedural Bill of Rights Act (California Government Code Section 3300 et. Seq.)

POLICY: 233.20
TITLE: ADVANCED EMT (AEMT SCOPE OF PRACTICE)

EFFECTIVE: 8/15/2025
REVIEW: 8/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ADVANCED EMT (AEMT) SCOPE OF PRACTICE

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.92, 1797.82, and 1797.171. Title 22, California Code of Regulations, Division 9, Chapter 2, Section 100106 and 100106.1

II. DEFINITIONS

A. **Agency** means the Mountain Counties Emergency Medical Services Agency.

B. **Advanced Emergency Medical Technician (AEMT)** means a California certified EMT with additional training in limited advanced life support (LALS) according to the standards prescribed by Chapter 3 of the Title 22, California Code of Regulations, Division 9.

C. **Base Hospital** means a hospital approved and designated by the Agency to provide immediate medical direction and supervision of EMT-I, EMT-II, and EMT-P personnel in accordance with policies and procedures established by the Agency.

D. **LALS** means Limited Advanced Life Support, as defined in Section 1797.92, Division 2.5 of the Health and Safety Code.

E. **Region** means the geographic jurisdiction of the Mountain Counties EMS Agency

III. PURPOSE

To define the AEMT scope of practice approved by the Agency Medical Director for use within the Region.

IV. POLICY

A certified AEMT or an AEMT trainee, as part of an organized EMS system, while caring for patients in a hospital as part of their training or continuing education, under the direct supervision of a Physician or Registered Nurse, or while at the scene of a medical emergency or during transport, or during interfacility transfer is authorized to do all of the following according to the policies and procedures

approved by the Agency:

A. Perform any activity identified in the Agency scope of practice policy of an EMT (MCEMSA Policy 236.00).

B. Perform pulmonary ventilation by use of a perilaryngeal airway adjunct.

C. Perform trachea-bronchial suctioning of an intubated patient.

D. Institute intravenous (IV) catheters, saline locks, needle or other cannulaee (IV lines), in peripheral veins.

E. Administer the following intravenously:
1. Glucose solutions;
2. Isotonic balanced salt solutions (Including Ringer's Lactate solution);
3. Naloxone;
4. Intravenous administration of 10% dextrose for adult patients, and 10% or 25% dextrose for pediatric patients.

E. Establish and maintain intraosseous access in a pediatric patient.

F. Obtain venous and/or capillary blood samples for laboratory analysis.

G. Use blood glucose measuring device.

H. Administer the following drugs in a route other than intravenous:
1. Activated charcoal;
2. Aspirin;
3. Epinephrine;
4. Glucagon;
5. Inhaled beta-2 agonists (bronchodilators);
6. Naloxone;
7. Sublingual nitroglycerine preparations

POLICY: 236.00
TITLE: EMT Scope of Practice

EFFECTIVE: 10/9/19

REVIEW: 10/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMT SCOPE OF PRACTICE

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.170; Title 22, California Code of Regulations, Division 9, Chapter 2, Section 100063.

II. DEFINITIONS

A. "Agency" means the Mountain-Valley EMS Agency.

B. “Basic Life Support” or “BLS” means care provided by prehospital providers that includes first aid, cardiopulmonary resuscitation and other non-invasive care; which includes airway adjuncts.

C. “Emergency Medical Technician or “EMT” means a person who has successfully completed a basic EMT course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and is certified in the State of California as an EMT.

D. “Region” means the geographic jurisdiction of the Mountain-Valley Emergency Medical Services Agency.

III PURPOSE

To define the EMT’s scope of practice approved by the Agency Medical Director for use within the Region.

IV. POLICY

During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a supervised EMT student or certified EMT is authorized to do any of the following in accordance with the written policies and procedures of the Agency:

A. Evaluate the ill and injured.

B. Render Basic Life Support, rescue and emergency medical care to patients.

C. Obtain diagnostic signs to include, but not limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.

D. Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.

E. Administer oxygen.

F. Use of the following adjunctive airway and breathing aids:
   1. Oropharyngeal airway;
   2. Nasopharyngeal airway;
   3. Perilaryngeal and supraglottic airways (such as King Tube or iGel);
   4. Suction devices;
   5. Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
   6. Manual and mechanical ventilating devices designed for pre hospital use including continuous positive airway pressure (CPAP) and/or bag valve mask.

G. Administer naloxone by intranasal and/or intramuscular routes for suspected narcotic overdose.

H. Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma.

I. Administer epinephrine by an agency approved injection kit for anaphylaxis

J. Perform finger stick blood glucose testing

K. Use various types of stretchers and body immobilization devices.

L. Provide initial prehospital emergency care of trauma patients, including, but not limited to:
   1. Bleeding control through the application of tourniquets
   2. Use of state approved hemostatic dressings
   3. Spinal movement restriction
   4. Extremity splinting
   5. Traction splinting
   6. Extrication of entrapped persons
   7. Provide field triage
   8. Transport patients
   9. Apply mechanical patient restraint

M. Administer the following over the counter medications by mouth:
   1. Oral glucose or sugar solutions; and
   2. Aspirin (324 mg)

N. Set up for ALS procedures, under the supervision of a Paramedic.

O. Perform automated external defibrillation

P. Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, metered dose inhalers, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

   In cases of assistance with nitroglycerin tablets or spray, the EMT shall monitor administration to ensure that doses are given at the prescribed times and in the prescribed amounts. If no specific directions are noted on the prescription, the EMT shall ensure that doses are given at five (5) minute intervals and that no more than a total of three (3) doses are given. Blood pressure will be taken and recorded prior to each dose. The EMT should not assist with the administration of medication when blood pressure is less than 100 mmHg

systolic OR either the patient complains of or the patient assessment shows an altered level of consciousness.

Q. During inter-facility transport, the EMT may monitor, maintain a preset rate of flow and turn off if necessary, glucose solutions or isotonic balanced salt solutions including Ringer's Lactate for volume replacement, medication delivery, or to maintain intravenous access. The IV solution may not contain any medications. The only action an EMT may take is to monitor the rate or turn off the infusion if infiltration of the IV occurs.

R. EMTs may transfer and monitor patients with the following invasive tubes and other medical adjuncts:

1. Nasogastric Tubes

    a. Nasogastric tubes shall be clamped. No form of suction shall be allowed during transport.

    b. A nasogastric tube shall be secured to the nose appropriately and shall also be secured to the patient's clothing to prevent accidental dislodgement or patient discomfort.

    c. Any tubing shall be clamped, and no feedings shall be infused during transport to prevent the possibility of aspiration.

    d. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler's position to help prevent the possibility of aspiration.

2. Abdominal Tubes (Gastrostomy tubes, ureterostomy tubes, wound drains, etc.) EMT's shall check that abdominal tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.

    a. Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.

    b. Any dressing drainage shall be noted and charted.

    c. Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.

3. Foley Catheters

    a. Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact, and the drainage bag is secured to prevent dislodgement, disconnection and backflow.

    b. If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the Foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.

4. Tracheostomy Tubes

    a. Tracheostomy tubes shall be checked to assure they are secured to the patient in an

appropriate fashion.

b. EMTs may suction **at the opening only** to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.

c. If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile saline and gently reinsert it or allow the patient to reinsert it if capable.

POLICY: 237.00
TITLE: Continuing Education for Pre-Hospital Personnel

EFFECTIVE: 8/15/2025
REVIEW: 8/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CONTINUING EDUCATION FOR PRE-HOSPITAL PERSONNEL

I. AUTHORITY

Division 2.5, Health and Safety Code, Section 1797.208; and Title 22, California Code of Regulations, Division 9, Chapter 11.

II. DEFINITIONS

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

National Standard Curriculum means the curricula developed under the auspices of the United States Department of Transportation, National Highway Traffic Safety Administration for the specified level of training of EMS Personnel.

III. PURPOSE

The purpose of this policy is to provide information for Pre-hospital Personnel and Continuing Education (C.E.) providers regarding classes and courses that meet the requirements for continuing education credit.

IV. POLICY

In order to acquire acceptable continuing education credit Pre-Hospital personnel shall attend classes and courses that are provided by Continuing Education Providers approved either by the Mountain Counties EMS Agency, another Local EMS Agency or the California State EMS Authority.

Continuing Education Providers approved by Mountain Counties EMS Agency shall adhere to the provisions of this policy when issuing continuing education credit for classes or courses offered for continuing education.

V. PROCEDURE

A. Continuing Education Credit shall be granted for:
   1. Courses in any of the topics contained in the respective National Standard Curriculum for training EMS personnel.

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

medical care (e.g., surgical airway procedures).

B. Delivery formats for CE Courses shall be any of the following:
   1. Classroom - didactic and/or skills laboratory where direct interaction with instructor is possible.

   2. Organized field care audits of patient care records.

   3. Field exercises that pertain to EMS functions.

   4. Courses offered by accredited universities and colleges, including junior and community colleges.

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

   6. Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules).

   7. Precepting EMS students or EMS personnel as assigned by an EMS training program, or an EMS service provider. CE for precepting can only be given for actual time spent precepting a student or EMS personnel and must be issued by the EMS training program or EMS service provider that has an agreement or contract with the field preceptor or with the Preceptor's employer. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider must be a CE provider.

C. Limitations

   1. At least 50% of the required CE hours must be in a format that is instructor based, which means that instructor resources are readily available to the student to answer questions, provide feedback, provide clarification and address concerns (e.g. on line CE courses where an instructor is available to the student). This provision shall not include precepting or magazine articles for CE credit. The Mountain Counties EMS Agency shall determine whether a CE course, class or activity is instructor based.

   2. During a certification or licensure cycle, an individual may receive credit, one time only, for services as a CE course, class, or activity instructor. Credit received shall be the same as the number of CE hours applied to the course, class, or activity.

   3. During a certification or licensure cycle, an individual may receive credit, one time only, for services as an instructor for an approved EMT, Advanced EMT, or Paramedic training program, except that the hours of service shall not exceed 50% of the total CE hours required in a single certification or licensure cycle.

   4. When guided by the EMS service providers QI program, an EMS service provider that is an approved CE provider may issue CE for skills competency demonstrations to address any deficiencies identified by the service provider QI program. Skills competency demonstration shall be

conducted with the respective National Standard Curriculum skills outline or in accordance with the certification policies of the Mountain Counties EMS Agency.

5. An individual may receive credit for taking the same CE course, class, or activity no more than two times during a single certification or licensure cycle.

6. If it is determined through a QI program that EMS personnel working in a local EMS system need remediation or refresher in an area of the individual's knowledge and/or skills, the Mountain Counties EMS Agency Medical Director or an EMS service provider may require the EMS personnel to take an approved CE course with learning objectives that addresses the remediation or refresher needed, as part of the individual's required hours of CE for maintaining certification or licensure.

7. Because paramedic licensure renewal applications are due to the EMS Authority thirty (30) days prior to the expiration date of a paramedic license, a CE course taken in the last month of a paramedic's licensure cycle, may be applied to the paramedic's subsequent licensure cycle, if that CE course was not applied to the licensure cycle during which the CE course was taken.

D. Continuing Education Records

1. CE shall be completed during the current certification or licensure cycle, except as noted for paramedics in Section IV.A.4.g of this policy.

2. In order for CE to satisfy the requirements for renewal of a lapsed certificate or license, CE shall be valid for a maximum of two years prior to the date of submission of a completed application for certificate or license renewal.

3. EMS personnel shall maintain for four years, CE certificates issued to them by any CE provider.

4. CE certificates may be audited for cause by the certifying or licensing authority or as part of the certifying or licensing authority's continuing education verification process.

POLICY: 256.00
TITLE: Paramedic Scope of Practice

EFFECTIVE: 6-21-24
REVIEW: 6-2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PARAMEDIC SCOPE OF PRACTICE

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.206; 1797.214; 1797.218; 1797.220 and; 1797.221. Title 22, California Code of Regulations, sections 100144 and 100145.

II DEFINITIONS

A. "Advanced Emergency Medical Technician (AEMT)" means a California certified EMT with additional training in limited advanced life support (LALS) according to the standards prescribed by Chapter 3 of the Title 22, California Code of Regulations, Division 9.

B. "Agency" means the Mountain Counties Emergency Medical Services Agency.

C. "Emergency Medical Technician" or "EMT" means a person who has successfully completed an EMT course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and who is certified as an EMT in the state of California.

D. "Emergency Medical Technician Paramedic" or "EMT-P" or "Paramedic" or "Mobile Intensive Care Paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support, who is licensed by the state of California as a paramedic and accredited by the Agency Medical Director.

III PURPOSE

The purpose of this policy is to define the Emergency Medical Technician Paramedic scope of practice approved by the Agency Medical Director for use within Mountain Counties EMS Agency.

IV. POLICY

A. A Paramedic may perform any activity identified in the scope of practice of an EMT or an AEMT.

B. As part of the State approved basic scope of practice, a Paramedic student or an accredited Paramedic, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under 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, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:

1. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG)

2. Perform defibrillation, synchronized cardioversion and external cardiac pacing .

3. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps.

4. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.

5. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in spontaneously breathing patient.

6. Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines) in peripheral veins; and monitor and administer medications through pre-existing vascular access.

7. Institute intraosseous (IO) needles or catheters.

8. Administer intravenous or intraosseous glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.

9. Obtain venous blood samples.

10. Use glucose-measuring device.

11. Utilize Valsalva's maneuver.

12. Perform percutaneous needle cricothyrotomy.

13. Perform needle thoracostomy.

14. Monitor thoracostomy tubes.

15. Monitor and adjust IV solutions containing potassium equal to or less than 40 mEq./L.

16. Administer approved medications by the following routes: intravenous, intramuscular, subcutaneous, inhalation, transcutaneous, sublingual, oral or topical.

17. Administer, using prepackaged products when available, the following medications:

    a. 10% 25% and 50% Dextrose

    b. Acetaminophen

    c. Activated Charcoal

    d. Adenosine

    e. Aerosolized or Nebulized beta-2 specific bronchodilators;

    f. Amiodarone

    g. Aspirin

    h. Atropine Sulfate

    i. Calcium Chloride

j. Diazepam
k. Diphenhydramine Hydrochloride
l. Dopamine Hydrochloride
m. Epinephrine
n. Fentanyl
o. Glucagon
p. Ipratropium bromide
q. Ketoroloac
r. Lidocaine Hydrochloride
s. Lorazepam
t. Midazolam
u. Magnesium sulfate
v. Morphine Sulfate
w. Naloxone Hydrochloride
x. Nitroglycerin Preparation
y. Olanzapine
z. Ondansetron
aa. Oxytocin
bb. Pralidoxime Chloride
cc. Sodium Bicarbonate
dd. TXA
ee. Verapamil

C. As part of the State approved expanded scope of practice, a Paramedic student or an accredited Paramedic, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under 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, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:

1. Perform pediatric oral endotracheal intubation only if the paramedic is working for an CAMTS(Commission on Accreditation of Medical Transport Systems) approved program.

2. Administration of Ketamine for acute traumatic or burn injury in accordance with MCEMSA policy 554.47

3. Intravenous infusion of Heparin and Nitroglycerine – (Inter-Facility Transfer only – requires prior approval pursuant to MCEMSA Policy #552.62)

D. Base Hospital Physicians may order any medication or procedure within the local paramedic scope of practice for any patient condition regardless of the treatment protocols.

E. Any skill that is not identified in this policy shall not be performed by paramedics, or paramedic students, even if they are directly supervised by a physician or registered nurse.

POLICY: 261.00
TITLE: MICN AUTHORIZATION/RE-AUTHORIZATION

EFFECTIVE: 2/21/2025
REVIEW: 2/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

MICN AUTHORIZATION/RE-AUTHORIZATION

I. AUTHORITY

Division 2.5, Health and Safety Code, Section 1797.56; Division 2, Business and Professions Code, Section 2725; and Title 22, California Code of Regulations, Section 100168, (b) (7).

II DEFINITIONS

A. **Agency** means the Mountain-Valley Emergency Medical Services Agency.

B. **Base Hospital** means a hospital approved and designated by the Agency to provide immediate Medical Direction and supervision of Advanced Life Support care in accordance with policies and procedures established by the Agency.

C. **Mobile Intensive Care Nurse** (**MICN**) - means a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code, and who has been authorized by the Agency Medical Director to issue instructions to prehospital emergency medical care personnel within this region according to the Prehospital Treatment Guidelines developed by the Agency.

III PURPOSE

The purpose of this policy is to establish a process for authorization and re-authorization of Mobile Intensive Care Nurses.

IV. POLICY FOR MICN AUTHORIZATION

A. Registered Nurses in good standing who possess a California MICN course completion certificate and successfully fulfill MICN authorization requirements as established by the Agency, are eligible for authorization.

B. Candidate must successfully complete **all** requirements of this policy within six months of application.

C. MICN may apply for accreditation no more than three (3) times within any twelve (12) month period.

V. PROCEDURE

A. The candidate must submit an MICN application, provided by the Agency, which documents:

1. Current licensure as a California Registered Nurse.

2. Successful completion of an MICN course approved by the Agency or a course which meets or exceeds Agency requirements.

3. One year experience as a Registered Nurse.

4. Six months' experience as either as a

   a. Registered Nurse working in a critical care setting such as the intensive care unit, critical care unit or emergency department, or

   b. California-licensed Paramedic with 50 or more ALS patient contacts.

5. A copy of a valid Advanced Cardiac Life Support (ACLS) certificate from a training course which meets the standards established by the American Heart Association.

6. Region IV, Office of Emergency Services, four-hour Hospital Module, Multi-casualty Incident (MCI) Training

   Candidates who do not document the MCI training will be issued authorization for six months only. Candidates must acquire the training within this six-month period to be eligible for continued authorization for the full two-year cycle.

B. The candidate shall:

1. Pay the established fee. The Agency shall not process applications until all related fees are paid.

2. Sign an affidavit that he/she is not precluded from authorization for any reasons defined in Section 1798.200 of the Health and Safety Code.

3. Pass a written MICN examination with a minimum score of 75% and a written protocol examination with a minimum score of 80%. A candidate who fails either the MICN exam or the protocols exam is eligible to retake the appropriate exam(s) within 60 days. A score of 80% or higher shall be required to pass the repeat exams. A candidate may not take the exam(s) a third time without completing additional criteria as required by the Agency Medical Director.

4. Provide a photograph for identification purposes.

5. Satisfactorily complete one of the following pre-authorization Base Hospital evaluation pathways:

   a. No less than 10 ALS base hospital radio calls supervised by a Mobile Intensive Care Nurse or Base Hospital Physician or

   b. No less than 3 ALS radio calls if the applicant is currently an authorized MICN in good standing and submits a letter of reference from the MICN's most recent Base Hospital Medical Director or Nurse Liaison verifying the MICN's satisfactory performance in handling ALS radio calls within the last two-year period.

C. Upon satisfactory completion and submission of the requirements of this policy, the candidate will be issued authorization for a maximum period of two (2) years. The effective date of authorization shall be the date the candidate satisfies all authorization requirements. The authorization expiration date will be the final day of the final month of the two (2) year period.

MICN RE-AUTHORIZATION

I. PROCEDURE

A. Prior to expiration of current authorization, the candidate shall:

1. Submit a completed Agency application which includes:

a. Payment of established fee(s). The Agency shall not process applications until all required fees are paid.

b. A signed affidavit that the candidate is not precluded from authorization for any reason defined in Division 2.5, Health and Safety Code, Section 1798.200.

c. Documentation of current California Registered Nurse license.

d. Photo identification.

e. Verification of successful completion of all continuing education requirements during the authorization period. Continuing education for each MICN shall include, at a minimum:

i. Sixteen (16) hours of formal education, relating specifically to ALS pre-hospital care.
ii. Any additional continuing education prescribed by the EMS Agency Medical Director which may include ride time with ALS contacts.

B. Upon satisfactory completion of the requirements of this policy, The MICN will be issued authorization for a maximum period of two years. The new effective date of authorization shall be the day after their current authorization expires. The certification expiration date will be the final day of the final month of the two (2) year period.

1. If an MICN applies for reauthorization more than six (6) months before their current authorization expires, they will be issued a new beginning authorization date effective the day that they meet the reauthorization requirements.

C. Individuals applying for reauthorization, whose authorization has lapsed, shall be eligible for reauthorization upon submission of documents indicating:

1. For a lapse of less than one (1) year:
Completion of all above requirements, plus a prorated amount of continuing education based on the number of months since the last authorization, not to exceed a total of 36 hours.
2. For a lapse of one (1) to two (2) years: MOUNTAIN COUNTIES EMS AGENCY MICN REAUTHORIZATION POLICIES AND PROCEDURES

a. Completion of all above requirements, including the prorated amount of continuing education and;

b. Successful evaluation by an authorized MICN or Base Hospital Physician of ten (10) ALS radio calls.

3. For a lapse of more than (2) years:

a. Completion of all above requirements and any additional training or evaluation required by the Agency Medical Director

VI. NEGATIVE ACTION

A. The EMS Medical Director may, for good cause, deny, suspend, revoke, or place on

probation any accreditation issued pursuant to this policy.

B. Any action taken against accreditation is independent of any notification made to the Board of Registered Nursing for investigation and/or licensure action. However, the Base Hospital Coordinator will immediately be notified of all inquiries, complaints, and/or investigations.

POLICY: **291.00**
TITLE: **PREHOSPITAL CARE CONTINUING EDUCATION PROVIDER**

EFFECTIVE: 10/17/25
REVIEW: 10/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PREHOSPITAL CARE CONTINUING EDUCATION PROVIDER

I. AUTHORITY
Title 22, Division 9, Chapter 11 of the California Code of Regulations (CCR)

II. DEFINITIONS

A. **Agency** means the Mountain-Valley Emergency Medical Services Agency.

B. **Applicant** means an individual or organization requesting to become an approved C.E. Provider.

C. **CEH** means Continuing Education Hour

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

E. **Emergency Medical Services (EMS) CE provider** means an individual or organization approved by the requirements of Title 22, Division 9, Chapter 11 of the CCR, to conduct continuing education courses, classes, activities or experiences and issue earned continuing education hours to EMS Personnel for the purposes of maintaining certification/licensure or re-establishing lapsed certification or licensure.

F. **EMS Service Provider** means an organization employing certified EMT, AEMT, or licensed paramedic personnel for the delivery of emergency medical care at the scene of an emergency, during transport, or interfacility transport.

G. **EMS System Quality Improvement Process** means methods of evaluation that are composed of structure, process and outcome evaluations which focus on the improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes and take steps to correct the process.

III. PURPOSE
To establish requirements for CE Providers, standards for Prehospital CE, performance requirements for CE Providers, delivery formats and limitations, record keeping, and procedures for the approval and denial, suspension or revocation of CE Provider status.

IV. POLICY

A. CE Provider Applicant Qualifications

1. Have a designated Program Director who is:

a. Qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. Program director qualifications shall be documented by one of the following:

i. California State Fire Marshal “Fire Instructor 1A and 1B";or

ii. National Fire Academy "Fire Service Instructional Methodology" course; or

iii. A training program that meets the most current U.S. Department of Transportation/National Highway Traffic Safety Administration Guidelines for Educating EMS Educators

iv. Individuals with experience may be provisionally approved for up to two years by the approving authority Executive Director or Medical Director pending completion of the above specified requirements. Individuals with experience who teach in geographic 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.

v. Specific requirements are found in Title 22, Section 100395(g).

b. Responsible for administering the CE program and ensuring adherence to state regulations, state guidelines and Agency policies, approval of course content, examinations, selection of instructors and coordination of all aspects of the educational activities.

c. Approving course, class, or activity including instructional objectives, and assigning CEH to any CE program which CE provider sponsors, and, but not limited to:

i. Approving all methods of evaluation, coordinating all clinical and field activities approved for CE credit;

ii.Approving the instructor(s) and signing all course, class, or activity completion records and maintaining those records in a manner consistent with this policy and Title 22, Division 9, Chapter 11 of CCR.

*The responsibility for signing course, class, or activity completion records may be delegated to the course, class, or activity instructor.

iii.Issuance of CE certificates.

iv. Maintenance and storage of course records for a period of not less than four years including the ability to retrieve any record if requested within 72 hours.

2. Have an approved Clinical Director who:

a. Is currently licensed as a physician, registered nurse, physician assistant, or paramedic.

b. Has two years of academic, administrative or clinical experience in emergency medicine or prehospital care within the last five (5) years.

c. Shall monitor all clinical and field activities approved for CE. credit, approve the instructor(s), and monitor the overall quality of the pre-hospital content of the program.

d. Specific requirements are found in Title 22 100395(i).

3. Utilize instructors who are approved by the Program Director and Clinical Director and who are currently licensed or certified in their area of expertise, if appropriate; or

a. 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

b. Have at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching; or

c. Be knowledgeable, skillful and current in the subject matter of the course or activity.

d. Specific requirements are found in Title 22 100170.

B. Courses Eligible for CE Credit

In order for CE Providers to grant CE Credit the courses must:

1. Be directly relevant to the practice of prehospital emergency medical care or; be related to the scientific knowledge or technical skills required for the practice of EMS delivery or; be related to direct or indirect patient care;

2. Be current and designed to include recent developments in the subject area;

3. Have written instructional objectives which are measurable and stated in behavioral terms or; provide a clear, concise description of course content in brochures and other publicity so that the participants will know in advance what they can expect to learn;

4. Include a written and/or skills competency based evaluation related to course, class, or activity objectives.

C. Continuing Education Hour (CEH)

1. One CEH is any one of the following:

a. Every fifty (50) minutes of approved classroom or skills laboratory activity

b. Each hour of structured clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to Title 22, Division 9, Chapter 11 of CCR.

c. Each hour of media based/serial production CE as approved by the CE provider approving authority

2. Continuing Education courses or activities shall not be approved for less than half hour increments.

3. Ten CEHs will be awarded for each academic quarter unit or fifteen CEHs will be awarded for each academic semester unit for college courses in physical, social or behavioral sciences (e.g., anatomy, physiology, sociology, psychology).

4. CE hours will not be awarded until the written and/or skills competency based evaluation related to course, class, or activity objectives has been met.

D. Certificates and Documents as Proof of Completion

CE providers must issue a tamper resistant certificate to each participant within thirty (30) days of the date of course completion to show that individuals have met the established criteria for successful completion of the course. Certificates must:

1. Be issued to only those individuals who attended the entire course.

2. Contain:

a. Name of participant.
b. Certification/license number.
c. Class title
d. CE Provider name and address
e. Date(s) of course, class, or activity
f. Number of CE hours.
g. Signature of course instructor or program director.
h. The following two statements:

1) ”This course has been approved for (number) hours of continuing education by approved California EMS CE provider (number) and was (check one) _____ instructor based, _____ non-instructor based”

2) "This documentation must be retained for a period of four (4) years."

E. Provider Records

CE providers shall keep course records for a minimum of four years including:

1. Course title
2. Course objectives
3. Course outlines
4. Record of place and date of each course.
5. Qualifications of each instructor.
6. Name of EMS personnel completing each course, and a record of any certificate issued to them.

7. Course sign-in rosters.
8. Course evaluations.
9. A copy of tests that were administered

F. Advertisement

Course advertisements must include the following:

1. A clear, concise description of the course content, objectives, cost and the intended audience (e.g. First Responder, EMT, AEMT, Paramedic, or all).

2. Specification of the number of hours of CE credit to be granted.

3. Provider name and number as on file with the EMS Agency.

4. The CE provider's policy on refunds in cases of non-attendance by the registrant or cancellation by provider, if applicable.

G. Audits

Representatives of the EMS Agency may make periodic site visits to courses, examine records, observe any related activities, and monitor compliance with this policy. Any requests made by the EMS Agency shall be provided within 72 hours of request.

V. PROCEDURE

A. CE Provider Application Process

1. An applicant must complete and submit an application form secured from the EMS Agency.

2. An applicant must pay all appropriate application fees.

3. The EMS Agency shall notify the applicant within fourteen (14) days that the application was received.

4. The EMS Agency shall review the application and notify the applicant within sixty (60) days that the application is approved or denied.

5. The approved applicant shall be assigned a CE provider number by the EMS Agency.

6. Approval shall be valid for not more than four years. Any CE provider who wishes to continue to provide courses with CE credit for Pre-hospital Care personnel shall reapply to the EMS Agency at least 60 days prior to their expiration date in order to maintain continuous approval.

7. CE provider shall not issue CEH’s until they have received a written letter by the Agency of approval as CE provider.

B. Denial, Suspension, Revocation of C.E. Provider Status

Noncompliance with any criterion required for CE provider approval, use of any unqualified teaching personnel, or noncompliance with any provision of this policy may result in denial, probation, suspension, or revocation of CE provider approval.

C. Appeals Process for Denial, Suspension or Revocation

1. Notification of noncompliance and action to place on probation, suspend or revoke CE provider status shall be carried out as follows:

a. Agency shall notify the approved CE provider program director in writing, by certified mail, of the provision of this policy with which the CE provider is not in compliance.

b. Within fifteen (15) days of receipt of the notification of noncompliance, the approved CE provider shall submit in writing, by certified mail, to the Agency, one of the following:

1) Evidence of compliance with the provision of this policy; or

2) A plan for meeting compliance with the provisions of this policy within sixty (60) days from the date of receipt of the notification of noncompliance.

3) Within fifteen (15) days of receipt of the response from the approved CE provider, or within thirty (30) days from the mailing date of the noncompliance notification if no response is received from the approved CE provider, the Agency shall notify the EMS Authority and the approved CE Provider in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, or place on probation, suspend or revoke the CE provider approval.

4) If the Agency decides to place on probation, suspend or revoke the CE provider's approval, the notification shall include the beginning and ending dates of the probation or suspension and terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) days from the date of the Agency's letter of decision to the EMS Authority and the CE provider.

5) If CE provider status is suspended or revoked, approval for CE credit shall be withdrawn for all CE programs scheduled after the date of action.

6) The Agency shall notify the EMS Authority of each CE provider approved, placed on probation, suspended or revoked within thirty (30) calendar days of action.

POLICY: 407.00
TITLE: Ground Ambulance Equipment and Medical Supply Inventory

EFFECTIVE: 6/21/2024
REVIEW: 6/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GROUND AMBULANCE EQUIPMENT AND MEDICAL SUPPLY INVENTORY

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.220 and 1798(a) and Title 22, California Code of Regulations, Section 100168.

II. DEFINITIONS

A. "Agency" means Mountain Counties EMS Agency.

B. "Advanced Life Support (ALS) Ambulance" means an ambulance that meets the requirements of a BLS Ambulance, and, in addition, is equipped to provide advanced life support care.

C. "Basic Life Support (BLS) Ambulance" means an ambulance that is specifically constructed, modified, or equipped, and used for transporting sick, injured, convalescent, infirm, or otherwise incapacitated persons and is limited to providing basic life support care.

D. "Minimum Inventory" means the minimum inventory required to respond to emergencies.

E. "Standard Inventory" means inventory that each unit shall normally carry and must be stocked with at the beginning of each shift.

III. PURPOSE

To establish a minimum and standard equipment medical supply inventory to ensure that optimal emergency medical care can be provided in accordance with the Agency Basic Life Support and Advanced Life Support Treatment Protocols. This policy is not intended to address non-transporting units.

IV. POLICY

A. Each BLS and ALS ground ambulance shall be completely stocked with the standard equipment and medical supply inventory at the beginning of each shift listed under V. Procedures, C. Equipment and Medical Supply Matrix.

B. If a BLS or ALS ground ambulance is requested by an authorized dispatch agency to respond to an emergency or non-emergency call before the unit has completely re-stocked, the unit may respond if it has the Minimum Inventory, as identified in this policy. The missing Standard Inventory items must be replaced as soon as possible.

C. If a ground ambulance has depleted supplies beyond the minimum inventory, it may still respond as a first response unit and, in the case of an ambulance, may transport only if the patient will not be affected by the missing inventory. An Unusual

Occurrence Report shall be submitted to the Agency for each response the ground ambulance goes on wherein it is not carrying the Minimum Inventory.

D. "Minimum Inventory" on a ground ambulance is one half (1/2) of the Standard Inventory. If the standard equipment and supply inventory amount is listed as a quantity of one (1) then the minimum inventory will be one (1).

E. The Agency may approve, on a provider specific basis, the use of ancillary equipment not included in this policy to achieve/perform a skill or procedure currently within the scope of practice for prehospital personnel.

1. A provider shall submit a written request to utilize ancillary equipment that includes the type of equipment, timeline for implementation, and the training program, to the Agency for approval by the Medical Director.

2. Training and implementation of ancillary equipment shall not begin until written approval is received from the Agency.

V. PROCEDURE

A. Shift Inventory:

The oncoming crew shall perform an equipment and medical supply inspection at the beginning of each shift to ensure each unit is completely stocked with the Standard Inventory.

B. Medication and IV Solution Maintenance:

1. The expiration date of all medications and IV Solutions on all units shall be checked on the first day of each month. All medications that expire in less than 30 days shall be exchanged.

2. Providers shall have policies and procedures in place that address appropriate equipment and medical supplies to be carried to the patient based on initial information.

3. Controlled substances are to be stored in accordance with Agency Policy 439.00 Controlled Substances.

4. ALS Service Providers shall take provisions to maintain medications and IV solutions within the temperature range recommended by the manufacturer.

C. Equipment and Medical Supply Matrix:

All ALS and BLS ground ambulances shall maintain the minimum equipment and medical supply inventory as indicated in the following matrices.

- * Comparable Device – A device marked with the asterisk (*) sign allows another device to be substituted, which has equal quality to perform the task at hand. For example, a Pediatric Immobilization Device can be substituted with a long backboard.
- + Optional Item – An item marked with the plus (+) sign is an item available to be chosen by the provider but is not obligatory.

	STANDARD INVENTORY For GROUND AMBULANCES	BLS		ALS
1.	KED	1		1

	STANDARD INVENTORY For GROUND AMBULANCES	BLS		ALS
2.	Scoop Stretcher	1		1
3.	Spinal Immobilization Board	2		2
4.	Backboard Straps	3 sets		3 sets
5.	Pediatric Immobilization Device or *Comparable Device	1		1
6.	Patient Carry Tarp	1		1
7.	Burn Pack (clean sheets, towels, gown, sterile gloves)	1		1
8.	Rigid Collars adjustable – Adult and Pediatric	2 each		4 each
9.	Foam Head Restraints or *	3		3
10.	Cold Packs	4		4
11.	Hot Packs	4		4
12.	Traction Splints (adult & pediatric)	1 each		1 each
13.	Rigid Extremity Splints (leg & arm, pediatric and adult)	1 each		1 each
14.	Petroleum Jelly Gauze (Sterile)	2		4
15.	5" x 9" ABD Pad	4		4
16.	4" x 4" Sterile Compress	4		4
17.	4" Kerlix Gauze Rolls	2		4
18.	Bandage Shears	1		1
19.	10" x 30" or Large Universal Dressing	2		2
20.	Rolls of Tape – one must be hypoallergenic	Assorted		Assorted
21.	4" x 4" Non-Sterile Gauze Pads	1 package		1 package
22.	Triangular Bandage	2		2
23.	Exam gloves (Small, Medium, Large, and X-Large)	1 box each size		1 box each size
24.	Non-Latex Exam Gloves (Small, Medium, Large and X-Large)	2 pairs each		2 pairs each
25.	Thermometer, Medical Grade Non-Contact, Infrared	0		1
26.	Commercial/Pre-packaged OB pack meeting Title 13, Section 1103.2(a)(16) requirements that also includes survival blanket and scalpel	1		1
27.	Oral Pharyngeal Airways (sizes 00 through 6)	1 set		2 sets
28.	Nasal Pharyngeal Airways (sizes peds through adult)	1 set		2 sets
29.	Bag-Valve Device (neonate, pediatric, adult)	1 each		1 each
30.	Wall Mounted Flow Meters, Capable of 0-15 Liter/Minute Flow	2		2
31.	Nasal Cannulas (adult)	2		6
32.	Nasal Cannulas (pediatric)	2		4
33.	Oxygen Mask with Reservoirs (adult and pediatric)	2 each		4 each
34.	Oxygen Supply > 10 liters/min x 20 minutes	1		1
35.	Portable Oxygen Supply with Bottle and Regulator	2		2
36.	Wrench for Oxygen Valve	1		1
37.	Suction Handle Tip Rigid Catheters	2		2
38.	Non-collapsible suction tubing	2		2
39.	Suction devices, stationary & portable	1 each		1 each
40.	Suction catheters size 6 – 14 French	0		1 each

	STANDARD INVENTORY For GROUND AMBULANCES	BLS		ALS
41.	Bite stick	1		2
42.	Peri laryngeal or Supraglottic Airway Device - King Airway or i-Gel manufacturer recommended sizing – Adult and Pediatric	1 each size		2 each size
43.	Bougie	0		2
44.	ETCO2 Detector	0		2
45.	12-lead EKG Monitor with paper print out capable of transcutaneous pacing; wave form capnography with recording capability; defibrillator with variable power control and a range capability of 25-360 joules (or clinically equivalent biphasic energy doses). All monitor/defibrillators shall have the capability to perform synchronized cardioversion	0		1
46.	CPAP device capable of delivering adjustable pressures ranging from 5 - 10 cm H_2O with FiO_2 concentrations equal to or greater than 30% oxygen and capable of fitting small, medium, and large adult sizes	1 each		1 each
47.	Laryngoscope Handle with two sets of batteries	0		2
48.	Disposable Laryngoscope blades 1 set (sizes 4 to 0) Miller	0		1 set
49.	Disposable Laryngoscope blades 1 set (sizes 4 to 1) Macintosh	0		1 set
50.	Endotracheal tubes and adapters ranging in size from 5.5 through 9.5 (cuffed) in increments of 0.5 mm	0		1 set
51.	Endotracheal tube stylets to fit all size tubes	0		1 set
52.	Magill forceps both child and adult sizes	0		1 each
53.	Nasogastric Rube, Adult and Pediatric sizes	0		1 each
54.	Water soluble lubrication jelly	3		3
55.	Nebulizer (hand-held and mask style)	0		2 each
56.	IV Catheter Needles Size 10 or 12 gauge OR approved Needle Decompression Kit	0		2
57.	Blood Pressure cuff adult	2		2
58.	Blood Pressure cuffs pediatric and extra long	1 each		1 each
59.	Broselow Tape - latest version	0		1
60.	Stethoscope	1		1
61.	Normal Saline for Irrigation 1000 mL	2		4
62.	Sheets, pillows, pillowcases, towels	2 sets		2 sets
63.	Blankets	2		2
64.	Ankle and wrist restraints	1 set		1 set
65.	Emesis Basin/Bag	4		4
66.	Bedpan	1		1
67.	Urinal	1		1
68.	Antibacterial disinfectant solution for cleanup	1		1
69.	EpiRite Syringe	2		0
70.	Pulse Oximeter	1		1
71.	Glucose Monitoring System	1		1
72.	Acetaminophen (Tylenol) IV 500mg/100ml or 1000mg/100ml	0		2
73.	Acetaminophen (Tylenol) 325 mg tablets	0		6

	STANDARD INVENTORY For GROUND AMBULANCES	BLS		ALS
74.	Acetaminophen (Tylenol) 160 mg/5 mL single dose cups	0		6
75.	Activated Charcol 50 Gram Suspension	0		2
76.	Adenosine 6 mg/2 mL concentration	0		36 mg
77.	Albuterol 3 mL of a 0.5% solution or 12 unit-dose vials	0		8
78.	Amiodarone 150 mg/3mL ampule **(Provider must carry either Amiodarone or Lidocaine or both)**	0		6 ampules
79.	Aspirin (chewable) 81 mg tablets	16 tablets		16 tablets
80.	Atropine Sulfate 1 mg/10 mL concentration (1 mg preload)	0		2
81.	Atropine Sulfate 20 mL of a 0.4 mg/1 mL concentration	0		1 vial
82.	Calcium Chloride	0		2 gm
83.	Dextrose 10% 250 ml bag	0		2
84.	Diphenhydramine (Benadryl) 50 mg/mL or 25 mg/ mL	0		100 mg
85.	Epinephrine 1:1,000 1 mg/mL	2 mg		3 mg
86.	Epinephrine 1:10,000 1 mg/10 mL (preloads)	0		10 mg
87.	Fentanyl 50 mcg/mL **(Provider must carry either Fentanyl or Morphine Sulfate or both, if they choose as outlined in MVEMSA Policy 439.00)**	0		200 mcg
88.	Glucagon 1 mg/mL	0		2 mg
89.	Instant Glucose	2 tubes		2 tubes
90.	+Ipratropium Bromide 0.5 mg/2.5ml+	0		4
91.	+ Ketamine w/ "KETAMINE ADMINISTERED" bands +	0		100 mg
92.	+Ketorolac (Toradol) 15 mg/ml+	0		30 mg
93.	+Levalbuterol 1.25mg/0.5 ml+	0		8
94.	Lidocaine 100 mg/5 mL (preloads) **(Provider must carry either Amiodarone or Lidocaine or both)**	0		3
95.	Magnesium Sulfate 500mg/ml, 10ml vial			4
96.	Midazolam (Versed) as outlined in MVEMSA Policy 439.00 – 20 mg (5 mg/mL) Maximum – 40 mg	0		20 mg
97.	**Morphine Sulfate –Maximum – 60 mg** **(Provider must carry either Fentanyl or Morphine Sulfate or both if they choose as outlined in MVEMSA Policy 439.00)**	0		20 mg
98.	Mucosal Atomizer 3 mL	2		4
99.	Naloxone (Narcan)	4 mg		12 mg
100.	Nitroglycerine spray bottle capable of providing a metered dose of 0.4 mg/spray	0		1 bottle with sufficient supply to treat 2 patients
101.	+ Nitroglycerine 0.4 mg tablets +	0		16 tablets
102.	Nitroglycerine Paste 2% ointment with tape for application	0		1 ointment
103.	Olanzapine (ODT) 10 mg tablets	0		5
104.	Ondansetron (Zofran) 4 mg tablets or 4 mg/2 mL vials	0		4
105.	Oxytocin 10 units/ml	0		2
106.	Sodium Bicarbonate 50 mEq/50 mL (preloads)	0		4
107.	TXA 1000 mg/10 mL	0		2
108.	Verapamil 5mg/2ml vial	0		3
109.	Betadine Preps	5		5
110.	Band-Aids Miscellaneous sizes	1 package		1 package

	STANDARD INVENTORY For GROUND AMBULANCES	BLS		ALS
111.	Medication added labels	0		Multiple 5each
112.	Intraosseous Needles (Stainless Steel) 15, 25 & 45 gauge either electronic or Jamshidi	0		2 each
113.	+ IO Drill +	0		1
114.	IV Catheter Needles Sizes 14 through 22 gauge	0		5 each
115.	Huber Needle 20 gauge, 1", bent tip, non-coring	0		2
116.	Needles for injections Size 18- or 19-gauge Size 24- or 25-gauge	0		3 each
117.	Normal Saline 1000 mL must be kept within a range of 100 to 110 degrees Fahrenheit. This cache of solution must be dated and either used or discarded within two weeks of warming.	0		2
118.	Normal Saline 250 mL	0		2
119.	Normal Saline 100 mL	0		2
120.	Normal Saline 1000 mL	0		6
121.	Macro-Drip Set (10-20 gtts/mL)	0		6
122.	Micro-Drip Set (60 gtts/mL)	0		2
123.	Pediatric 100 mL Volume Control Chamber Administration Sets	0		2
124.	Extension Tubing	0		6
125.	Syringes 1, 3, 5, 60 mL	0		2 each
126.	IV Tourniquets	0		5
127.	Sharps Container(s) as necessary, incl. one in ambulance and one in EMS bag	0		2
128.	Alcohol Preps	0		Multiple
129.	12-lead Electrode Pads	0		20
130.	Defibrillator Pads – Adult and Pediatric	0		2
131.	12-lead Monitor cables (one with monitor, one back-up)	0		2 sets
132.	Charged batteries (backups for defibrillator)	0		2
133.	AED with extra set of Pediatric and Adult pads	1		0
134.	Mountain Counties EMS Agency Policy 810.00 MCI Kit containing the following: Set of five MCI vests; 25 triage tags; Set of ICS Forms; Complete set of oral airways ranging from sizes 0-6; 4 additional airways in each of the following sizes 4,5,6; 4 – 4" x 4" trauma compresses with ties; 4 Tourniquets; Pair of bandage scissors/shears	1		1
135.	Radio able to communicate with authorized dispatch center in area of operation.	1		1
136.	Radio able to transmit and receive communications on appropriate med-net frequencies and private line tones with hospitals and DCF in unit's service area and surrounding counties. Radios used for communication with hospital must be accessible in the patient compartment.	1		1
137.	Portable radio able to transmit and receive communications with authorized dispatch center in area of operation.	1		1
138.	Cell Phone in compliance with contractual requirements	1		1
139.	+ Satellite Phone +	1		1

D. Recommended Inventory

The following matrix contains equipment and medical supplies recommended to be available to EMS responders on their person, in the unit, or in quarters for dispatch to the scene if necessary.

Recommended ITEMS per person	**Carried, Stored in Unit or In Quarters**	
Hard hat – Work helmet (Blue)	Unit	1 per person
Eye Protection	Carried	1 per person
Hearing Protection	Carried	1 per person
Body Garment (uniform blue)	Carried	1 per person
Garment – single use	Unit	1 per person
Hooded, chemical resistant clothing	Quarters	1 per person
Jacket – EMS w/reflective stripes	Unit	1 per person
Gloves – chemical-protective Nitrile	Unit	1 box
Gloves work	Unit	1 pair per person
Footwear worn	Carried	1 pair per person
Footwear covers	Unit	1 pair per person
N-100 or N-95 mask	Unit	5
Escape Hood	Carried	1 per person
Flashlight or headlamp	Carried	1 per person
Knife, folding	Carried	1 per person
Scissors/Shears	Carried	1 per person
Stethoscope	Carried	1 per person
Personal communication device (radio)	Carried	1 per person
Mark I Auto-injector Kit	Unit	1 per person
Recommended Extended Operations Equipment		
Daypack – "GO" pack for the following equipment		1
One quart water		1
One water purification unit		1
One set of rain gear		1
Set of emergency garments		1
MREs for 72 hrs.		1
1 set ear protection		1
Mark I Auto-injector Kit		1
Field Operations Guide (FOG)		1

POLICY: 409.00
TITLE: BLS and ALS First Responder Unit Equipment and Medical Supply Inventory

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

BLS AND ALS FIRST RESPONDER UNIT EQUIPMENT AND MEDICAL SUPPLY INVENTORY

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.220 and 1798(a) and; Title 22, California Code of Regulations, Section 100168.

II DEFINITIONS

A. **Agency** means the Mountain Counties EMS Agency.

B. **Advanced Life Support (ALS) First Responder Unit** (ALSFRU) means a vehicle, staffed by a minimum of one Paramedic, to provide ALS services pursuant to a written agreement between an ALS First Responder Department and the Agency.

C. **ALS Quick Response Vehicle (ALSQRV)** means a vehicle, staffed by a minimum of one Paramedic, to provide ALS services pursuant to a written agreement between an ALS Responder Department and the Agency.

D. **Basic Life Support (BLS) First Responder Unit (BLSFRU)** means a vehicle, staffed by a minimum of one EMT, to provide BLS services pursuant to a written agreement between a BLS First Responder Department and the Agency.

E. **BLS Quick Response Vehicle (BLSQRV**) means a vehicle, staffed by a minimum of one EMT, to provide BLS services pursuant to a written agreement between a BLS or ALS Responder Department and the Agency.

F. **Minimum Inventory** means the minimum inventory required to respond to emergencies.

G. **Standard Inventory** means inventory that each unit shall normally carry and must be stocked with at the beginning of each shift.

III PURPOSE

To establish a minimum and standard equipment and medical supply inventory for BLS, ALS First Responding, and QRV units. This policy is **not** intended to address transporting units.

IV. POLICY

A. Each BLS, ALS First Responder, and QRV Unit shall be completely stocked with the

standard equipment and medical supply inventory at the beginning of each shift listed under V. Procedures, C. Equipment and Medical Supply Matrix.

B. If a BLS, ALS First Responder, or QRV Unit is requested by an authorized dispatch agency to respond to an emergency or non-emergency call before the unit has completely re-stocked, the unit may respond as long as it has the Minimum Inventory, as identified in this policy. The missing Standard Inventory items must be replaced as soon as possible.

C. If a BLS, ALS First Responder, or QRV Unit has depleted supplies beyond the minimum inventory, it may still respond as a first response unit. An Unusual Occurrence Report shall be submitted to the Agency for each response the unit goes on wherein it is not carrying the Minimum Inventory.

D. **Minimum Inventory** on a BLS, ALS First Responder, or QRV Unit is considered to be one half (1/2) of the Standard Inventory. If the standard equipment and supply inventory amount is listed as a quantity of one (1) then the minimum inventory will be one (1).

E. The Agency may approve, on a provider-specific basis, the use of ancillary equipment not included in this policy to achieve/perform a skill or procedure currently within the scope of practice for prehospital personnel.

1. A provider shall submit a written request to utilize ancillary equipment that includes the type of equipment, timeline for implementation, and the training program to the Agency for approval by the Medical Director.

2. Training and implementation of ancillary equipment shall not begin until written approval is received from the Agency.

V. PROCEDURE

A. Shift Inventory:

The oncoming crew shall perform an equipment and medical supply inspection at the beginning of each shift to ensure each BLS, ALS First Responder, and QRV Unit is completely stocked with the **Standard Inventory**.

B. Medication and IV Solution Maintenance:

1. The expiration date of all medications and IV solutions on all ALS and QRV units shall be checked on the first day of each month. All medications and IV solutions that expire in less than 30 days shall be exchanged.

2. Providers shall have policies and procedures in place that address appropriate equipment and supplies to be carried to the patient based on initial information.

3. Controlled substances are to be stored in accordance with **Agency Policy 439.00 Controlled Substances**.

4. ALS Service Providers shall take provisions to maintain medications and IV solutions within the temperature range recommended by the manufacturer.

C. Equipment and Medical Supply Matrix:

All BLS, ALS First Responder QRV Units shall maintain the standard equipment and medical supply inventory as indicated in the following matrices.

- *Comparable Device – A device marked with the asterisk (*) sign allows another device to be substituted, which has equal quality to perform the task at hand. For example, a Pediatric Immobilization Device can be substituted by a long backboard.
- +Optional Item – An item marked with the pound (+) sign is an item available to be chosen by the provider but is not obligatory.

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	**BLSFRU**	**BLSQRV**	**ALSFRU**	**ALS QRV**
1.	KED/Vest Extrication Device	1	0	1	0
2.	Spinal Immobilization Board	2	0	2	0
	Patient Carry Tarp	1	1	1	1
	Backboard Straps	2 sets	0	2 sets	0
3.	Pediatric Immobilization Device or a Vest Extrication Device	1	0	1	0
4.	Burn Pack (clean sheets, towels, gown, sterile gloves)	1	1	1	1
5.	Rigid Collars – adjustable – Adult and Pediatric	4 each	2each	4 each	2each
6.	Foam Head Restraints or *	1	0	1	0
7.	Cold Packs	2	2	2	2
	Hot Packs	2	2	2	2
	Traction Splints (adult & pediatric)	1 each	0	1 each	0
8.	Rigid Extremity Splints (leg & arm; ped & adult)	1 each	0	1 each	0
9.	Petroleum Jelly (Sterile, Vaseline) gauze	4	4	4	4
10.	5 x 9 ABD Pads	4	4	4	4
11.	4 X 4 Sterile Compresses	4	4	4	4
12.	4” Kerlix Roll	4	4	4	4
13.	Bandage Shears	1	1	1	1
14.	10 X 30 inch or large universal dressings	2	2	2	2
15.	Rolls of Tape – one must be hypoallergenic	Assorted	Assorted	Assorted	Assorted

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
16.	4 X 4's Non-sterile, Bag	1 package	1 package	1 package	1 package
17.	Hemostatic Dressings	2	2	2	2
18.	Triangular Bandage	2	2	2	2
19.	Exam Gloves - small, medium, large, and x-large	1 box each	1 box each	1 box each	1 box each
20.	Non-Latex Exam Gloves - small, medium, large, and x-large	2 pairs each	2 pairs each	2 pairs each	2 pairs each
21.	Thermometer, Medical Grade Non-Contact Infrared	0	0	1	1
22.	Commercial/Pre-packaged OB pack meeting Title 13, section 1103.2(a)(16) requirements that also includes survival blanket and scalpel	1	1	1	1
23.	Oral Pharyngeal Airways (sizes 00 through 6)	1 set	1 set	1 set	1 set
24.	Nasal Pharyngeal Airways (sizes peds through adult)	1 set	1set	1 set	1 set
25.	Bag-Valve Device (adult, pediatric, neonate)	1 each	1 each	1 each	1 each
26.	Nasal Cannulas adult size	2	2	2	2
27.	Nasal Cannulas pediatric size	1	1	1	1
28.	Oxygen Mask with Reservoirs adult and pediatric size	2 each	2 each	2 each	2 each
29.	Portable Oxygen Supply with bottle and regulator >10 lpm x 20 minutes.	2	2	2	2
30.	Wrench for Oxygen Valves	1	1	1	1
31.	Suction Handle-Tip Rigid Catheters	1	1	1	1
32.	Non-collapsible Suction Tubing	1	1	1	1
33.	Portable Suction Device	1	1	1	1
34.	Suction Catheters 6-14 French	0	0	1 each size	1 each size
35.	Bite Stick	1	1	1	1
36.	Perilaryngeal or Supraglottic Airway Devices - King Airway or I-Gel manufacturer recommended sizing	1 each size	1 each size	1 each size	1 each size
37.	Bougie	0	0	1	1
38.	ETCO2 Detector			1	1

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
39.	CPAP device capable of delivering adjustable pressures ranging from 5 - 10 cm H_2O with FiO_2 concentrations equal to or greater than 30% oxygen and capable of fitting small, medium and large adult sizes.	1 each size	1 each size	1 each size	1 each size
40.	Laryngoscope Handle with one set of spare batteries	0	0	1	1
41.	Disposable Laryngoscope Blades 1 set Miller (sizes 4 to 0)	0	0	1 set	1 set
42.	Disposable Laryngoscope Blades 1 set Mac (sizes 4 to 1)	0	0	1 each	1 each
43.	Video Laryngoscope + with Approval of Agency Medical Director	0	0	1	1
44.	Endotracheal Tubes and Adapters ranging in size from 5.5 through 9.5 (cuffed) in increments of 0.5 mm.	0	0	1 set	1 set
45.	Endotracheal Tube Stylets to fit all size tubes	0	0	1 each	1 each
46.	McGill Forceps both child and adult sizes	0	0	1 each	1 each
47.	Nasogastric Tube, Adult and Pediatric	0	0	1 each	1 each
48.	Water Soluble Lubrication Jelly	3	3	3	3
49.	Nebulizer (hand-held and mask style)	0	0	2 each	2 each
50.	IV Catheter Needles Size 10 or 12 gauge OR approved NCD Kit	0	0	2	2
51.	Blood Pressure Cuff adult, pediatric and extra long	1 each size	1 each size	1 each size	1 each size
52.	Broselow Tape - latest version or an approved Length Based Tape	0	0	1	1
53.	Stethoscope	1	1	1	1
54.	Normal Saline for Irrigation	2	2	2	2
55.	Blankets	2	2	2	2
56.	Emesis Basins/Bags	2	2	2	2
57.	Antibacterial Disinfectant Solution for cleanup	1	1	1	1
58.	EpiRite Syringe-If approved for Draw Up Epinephrine Optional Scopeby MCEMSA	2	2	0	0
59.	Pulse Oximeter	1	1	1	1

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
60.	Glucose Monitoring System	1	1	1	1
61.	Acetaminophen (Tylenol) IV 500mg/100ml or 1000mg/100ml	0	0	2	2
62.	Acetaminophen (Tylenol) PO 325mg tablets	0	0	6	6
63.	Acetaminophen (Tylenol) 160mg/5ml single dose cups	0	0	6	6
64.	Activated Charcoal 50 gram suspension	0	0	2	2
65.	Adenosine 6 mg/2 ml concentration	0	0	18 mg	18 mg
66.	Albuterol 3 ml of a .5% solution	0	0	6 unit dose	6 unit dose
67.	Amiodarone 150mg/3ml ampule + **(Provider must carry either Amiodarone or Lidocaine or both if they choose)**	0	0	6 ampules	6 ampules
68.	Aspirin (chewable) tablets	0	0	16 tablets	16 tablets
69.	Atropine Sulfate 1 mg/10 ml concentration (1 mg preload)	0	0	2 preload	2 preload
70.	Atropine Sulfate 20 ml of a .4 mg/1 ml concentration	0	0	1 vial	1 vial
71.	Calcium Chloride	0	0	2 gm	2 gm
72.	Dextrose 10%,	0	0	2	2
73.	Diphenhydramine (Benadryl) 50mg/1ml or a 25 mg/ml concentration	0	0	100 mg	100 mg
74.	Epinephrine 1:1,000 (1 mg/ml)	2 mg	2 mg	3mg	3mg
75.	Epinephrine 1:10,000 (1mg/10ml)	0	0	6 mg	6 mg
76.	Epinephrine AutoInjector (Adult and Pediatric)	1 each	1 each	0	0
77.	Fentanyl 50 mcg/mL Maxinum-400mcg **(Provider must carry either Fentanyl or Morphine Sulfate or both, if they choose as outlined in MVEMSA Policy 439.00)**	0	0	200 mcg	200 mcg
78.	Glucagon 1mg/mL	0	0	1 mg	1 mg
79.	Instant Glucose	2 tubes	2 tubes	2 tubes	2 tubes
80.	+Ipratropium Bromide 0.5 mg/2.5mL+	0	0	4	4
81.	+Ketamine w/ "KETAMINE ADMINISTERED" bands+	0	0	500 mg	500 mg
82.	+Ketorolac (Toradol) 15mg/mL+	0	0	30 mg	30 mg

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
83.	+Levalbuterol 1.25mg/0.5mL+	0	0	8	8
84.	Lidocaine 100mg/10mL (preloads) **(Provider must carry either Amiodarone or Lidocaine or both, if they choose as outlined in MVEMSA Policy 439.00)**	0	0	3	3
85.	Magnesium Sulfate 500mg/mL, 10mL vial	0	0	2	2
86.	Midazolam as outlined in MVEMSA Policy 439.00 (Versed)–20 mg(5mg/ml) Maximum – 40 mg	0	0	20 mg	20 mg
87.	Morphine Sulfate –Maximum – 60 mg	0	0	20 mg	20 mg
88.	Mucosal Atomizer 3mL	2	2	2	2
89.	Naloxone (Narcan)	8 mg	8 mg	12 mg	12 mg
90.	+Nitroglycerin 0.4 Tablets+	0	0	1 bottle 16 tablets	1 bottle 16 tablets
91.	Nitroglycerin Paste 2% ointment with tape for application	0	0	1 ointment	1 ointment
92.	Nitroglycerin spray bottle capable of providing a metered dose of 0.4 mg/spray	0	0	1 bottle with sufficient supply to treat 2 patients	1 bottle with sufficient supply to treat 2 patients
93.	Olanzapine (ODT) 10mg tablets	0	0	5	5
94.	Oxytocin 10 units/mL	0	0	1	1
95.	Ondansetron (Zofran) 4.0 mg tablets or 4 mg/2 mL vials	0	0	2	2
96.	Sodium Bicarbonate 50 mEq/50 mL concentration	0	0	2	2
97.	TXA 1000 mg/10 mL	0	0	2	2
98.	Verapamil Vial 5mg/2mL	0	0	0	3
99.	Betadine Preps	0	0	5	5
100.	Band-Aids Miscellaneous sizes	1 package	1 package	1 package	1 package
101.	Medication Added Labels	0	0	5	5
102.	Intraosseous Needles (Stainless Steel) 15, 25 & 45 either electronic or Jamshidi	0	0	2 each	2 each
103.	+IO Drill +	0	0	1 each	1 each
104.	IV Catheter Needles Sizes 14 through 22 gauge	0	0	5 each	5 each
105.	Huber Needle 20 gauge, 1”, bent	0	0	1	1

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
	tip, non-coring				
106.	Needles for Injections 18 or 19 gauge Size 21,23,24, and 25	0	0	3 each	3 each
107.	Normal Saline 1000 mL must be kept within a range of 100 to 110 degrees Fahrenheit. This cache of solution must be dated and either used or discarded within two weeks of warming.	0	0	2	2
108.	Normal Saline 250 mL	0	0	2	2
109.	Macro-Drip Set (10-20 gtts/mL)	0	0	4	4
110.	Micro-Drip Set (60 gtts/mL)	0	0	2	2
111.	Pediatric 100 ml Volume Control Chamber Administration Sets	0	0	2	2
112.	Extension Tubing	0	0	4	4
113.	Syringes 1, 3, 5, 10, 60 ml	0	0	2 each	2 each
114.	IV Tourniquets	0	0	3	3
115.	Sharps Container(s) as necessary, incl. one in EMS Bag	1	1	1	1
116.	Alcohol Preps	5	5	5	5
117.	12-lead EKG Monitor with paper print out capable of transcutaneous pacing; wave form capnography with recording capability; defibrillator with variable power control and a range capability of 25-360 joules (or clinically equivalent biphasic energy doses). All monitor/defibrillators shall have the capability to perform synchronized cardioversion	0	0	1	1
118.	12-lead Electrode Pads	0	0	20	30
119.	Defibrillator Pads – Adult and Pediatric	0	0	2	2
120.	12-lead Monitor cables (one with monitor, one back-up)	0	0	1set	1set
121.	Charged Batteries (backups for defibrillator)	0	0	2	2
122.	AED with 1 extra set of pads for adult and children	1	1	0	0
123.	MCI Kit containing the following: Set of five MCI vests per Agency	1	1	1	1

	STANDARD INVENTORY FOR BLS, ALS FIRST RESPONDER and QRV UNIT	BLSFRU	BLSQRV	ALSFRU	ALS QRV
	Policy 810.00; 25 triage tags; Set of ICS Forms as specified in MVEMSA Policy 810.00; Complete set of oral airways ranging from sizes 0-6; 4 - Additional airways in each of the following sizes 4,5,6; 4 - 4 x 4 trauma compresses with ties; 4 - Tourniquets; Pair of bandage scissors/shears;				
124.	Radio able to communicate with authorized dispatch center in area of operation.	1	1	1	1
125.	Radio able to transmit and receive communications on appropriate med-net frequencies and private line tones with hospitals and DCF in unit's service area and surrounding counties.	0	0	1	1
126.	Portable radio able to transmit and receive communications with authorized dispatch center in area of operation.	1	1	1	1
127.	Cell Phone in compliance with contractual requirements	1		1	1
128.	+Satellite Phone +	1		1	1

D. Recommended Inventory

The following matrix contains drugs and equipment that is recommended to be available to EMS responders on their person, in the unit, or in quarters for dispatch to the scene if necessary.

Recommended Items per Person	Carried, Stored in Unit or In Quarters	Quantity
Hard Hat – Work helmet (Blue)	Unit	1 per person
Eye Protection	Carried	1 per person
Hearing Protection	Carried	1 per person
Body Garment (uniform blue)	Carried	1 per person
Garment – single use	Unit	1 per person
Hooded, chemical resistant clothing	Quarters	1 per person
Jacket – EMS w/reflective stripes	Unit	1 per person
Gloves – chemical-protective Nitrile	Unit	1 box
Gloves work	Unit	1 pair per person
Footwear worn	Carried	1 pair per person
Footwear covers	Unit	1 pair per person

Recommended Items per Person	Carried, Stored in Unit or In Quarters	Quantity
N-100 or N-95 mask	Unit	5
Escape Hood	Carried	1 per person
Flashlight or Headlamp	Carried	1 per person
Knife, folding	Carried	1 per person
Scissors/Shears	Carried	1 per person
Stethoscope	Carried	1 per person
Personal Communication Device (radio)	Carried	1 per person
Mark I Auto-injector Kit	Unit	1 per person
Recommended Extended Operations Equipment		
Daypack – "GO" pack for the following equipment		1
Onequart water		1
One water purification unit		1
One set of rain gear		1
Set of emergency garments		1
MREs for 72 hrs.		1
1 set ear protection		1
Mark I Auto-injector Kit		1
Field Operations Guide (FOG)		1

POLICY: 412.20
TITLE: EMS Transfer of Patient Care

EFFECTIVE: 11/01/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMS TRANSFER OF PATIENT CARE

I. AUTHORITY
Division 2.5, Health and Safety Code, Section 1797.220

II. DEFINITIONS

A. **Primary Paramedic** means the first Paramedic that makes patient contact at the scene of an emergency and has the lead responsibility to provide patient assessment and patient care until such responsibility is transferred to another Paramedic or EMT or Flight Nurse.

B. **Paramedic** means a currently licensed and accredited on-duty paramedic.

C. **Flight Nurse** means a Registered Nurse functioning as a member of an air ambulance crew.

D. **EMT** means a state certified Emergency Medical Technician

E. **Air Ambulance** - Means any rotor or fixed wing 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 a minimum of two (2) attendants certified in advanced life support.

F. **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.

G. **Basic Life Support Ambulance**: An emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III. PURPOSE

To ensure that a mechanism exists for appropriate transfer of patient care between Paramedics, EMTs, Flight Nurses, and Rescue Aircraft personnel.

IV. POLICY

A. The Primary Paramedic shall provide other assisting Paramedics, Flight Nurses, EMT's or Rescue Aircraft personnel who arrive on scene with all appropriate patient care information.

B. All Paramedics and Flight Nurses on scene have a duty to provide the Primary Paramedic with recommendations, based upon Mountain Counties EMS Agency treatment policies, and patient care assistance to ensure the best possible patient care as logistics permit and circumstances require.

C. Paramedics are authorized to transfer the role of Primary Paramedic to another Paramedic, EMT, Flight Nurse, or Rescue Aircraft personnel when patient condition permits.

D. A Paramedic may transfer patient care to Rescue Aircraft personnel under the following conditions:
1. An air ambulance is not readily available.

2. It is determined that rapid transport is a prime therapeutic intervention for the patient.

3. If Rescue Aircraft personnel are qualified at less than the Paramedic level, Base Hospital contact shall be made to determine whether or not the Rescue Aircraft will transport the patient.

4. If Base Hospital contact cannot be made, the Incident Commander in concert with the highest medically qualified person on scene, will decide whether the Rescue Aircraft will transport the patient.

E. In systems that are approved by the Agency to use a BLS tiered response, a Paramedic may transfer patient care to a Basic Life Support Ambulance staffed with two (2) EMTs when the following conditions are met:
1. The Paramedic assessment reveals a stable patient that in the Paramedic judgment leaves no index of suspicion that would require ALS treatment.

2. No ALS interventions have been started. Skills and medications within the EMT scope of practice DO NOT constitute ALS interventions.

3. Patient does not meet the unstable definitions as outlined below and as defined in MCEMSA policy 954.20 Stanislaus County BLS Tiered Response System
   - Potentially unstable adult patient:
     - Cardiac Arrest
     - Heart Rate < 50 or > 120
     - Systolic Blood Pressure < 90mmHg
     - Respiratory Rate > 24
     - 02 sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate

- Any patient that meets trauma activation criteria per MCEMSA Policy 553.25 Trauma/Burn Triage and Patient Destination
- Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.
    - Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
        - Tone
        - Interactiveness
        - Consolability
        - Look/gaze
        - Speech/cry
    - Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
        - Stridor
        - Wheezing
        - Grunting
        - Tripod positioning
        - Retractions
        - Nasal flaring
        - Apnea/gasping
    - Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
        - Pale
        - Mottled
        - Cyanotic
- Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

V. PROCEDURE

A. A Primary Paramedic that decides to transfer care to another Paramedic, EMT or Flight Nurse shall:

1. Only transfer primary patient care when merited by logistical or operational considerations.

2. Provide complete patient assessment and treatment information to the Paramedic, EMT or Flight Nurse accepting responsibility for the patient.

3. Ensure the completion of a patient care record per Agency policy.

B. The Primary Paramedic shall maintain the lead responsibility and accompany the patient during transport when requested by the EMT or receiving Paramedic due to the patient's condition or complexity of treatment.

C. Disagreements between Paramedics or between Paramedics, EMT's and Flight Nurses regarding the correct course of patient treatment shall be resolved:

1. In consultation with the Base Hospital, if still on scene.

2. Through their respective provider agency's QI program.

POLICY: 413.00
TITLE: Patient Destination

EFFECTIVE: 7-1-2024
REVIEW: 7-2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PATIENT DESTINATION

I. AUTHORITY
Division 2.5, California Health and Safety Code, Sections 1797.220, 1798 and: Title 22, California Code of Regulations, Chapter 4, Section 100168(b)(3).

II. PURPOSE
Provide guidance for determining appropriate destination decision to Prehospital care personnel.

III. DEFINITIONS

A. Most Accessible Facility: Nearest receiving hospital while considering traffic and weather conditions, or other factors impacting transport time.

B. Most Appropriate Facility: nearest receiving facility having specialized services likely to be required by patient conditions. These conditions include STEMI, Stroke, or Trauma Centers, or other specialty service(s) defined in Mountain Counties EMS Agency (MCEMSA) policy.

C. Receiving Hospital: Acute Care hospital licensed under Chapter 2 of Division 2, with a permit for Basic Emergency services, as determined by the Local EMS Agency (LEMSA).

D. Unstable Patient:

1. Patients with uncontrolled airway (defined as unable to maintain a BLS Airway) Example: IF patient can be ventilated via BVM without an advanced airway, SGA, or OPA, this is **NOT** an unstable airway.

2. Uncontrolled hemorrhage,

3. CPR in progress,

4. Deteriorating vital signs to the degree that it is reasonable to assume death or preventable disability is imminent.

IV. POLICY;
Patients should be transported to the facility of their choice whenever possible. The patient's ability to pay or socioeconomic status shall not be considered when determining destination.

A. Unstable Patients shall be transported to the Most Accessible Facility.

B. Patients that meet MCEMSA-defined specialty care triage criteria shall be transported to the Most Appropriate Facility. If transport time exceeds one hour to the requested facility or additional travel time may be detrimental to the patient, Base Hospital Physician shall be contacted for destination determination.

C. Stable and alert patients should be transported to the receiving facility of their, or legal guardian's, choice. If transport time exceeds one hour to the requested facility or additional travel time may be detrimental to the patient, Base Hospital Physician shall be contacted for destination determination.

D. Stable patients that cannot communicate their choice of facility:

Destination determination should be made by:

1. Family/Caretaker/Guardian's request
2. Private Physician's request
3. Facility where the patient has traditionally received medical care
4. Most accessible facility

E. Stable patients in the custody of Law Enforcement agency should be transported to the facility of the custodial officer's choice.

Mountain Counties
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 439.00
TITLE: Controlled Substance

EFFECTIVE: 10/25/24
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CONTROLLED SUBSTANCES

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.220 and 1798(a) and; Title 22, California Code of Regulations, section 100146, section 100167, section 100168 (b)(1).

II DEFINITIONS

A. **Advanced Life Support service provider** means an agency authorized by the Mountain Counties EMS Agency to provide ALS services

B. **ALS** means Advanced Life Support as defined in section 1797.52 of Health and Safety Code, Division 2.5.

C. **Back-up ALS unit** means a fully stocked, equipped and operational ALS unit intended to be put in service on an as-needed basis that is not currently staffed by a Paramedic who is responsible for the controlled substances on that unit.

D. **BLS** means Basic Life Support as defined in section 1797.60 of Health and Safety Code, Division 2.5.

E. **Controlled substances** means **drugs or chemicals regulated by government due to their potential for abuse, addiction, or harm and include** morphine sulfate, fentanyl, ketamine, and midazolam.

F. **In-Service ALS unit** means any ALS unit that is currently operational and staffed by a Paramedic, who is responsible for the controlled substances on that ALS unit.

G. **Out-of-Service ALS unit** means any ALS unit that is neither currently operational nor staffed by a Paramedic who is responsible for the controlled substances on that ALS unit.

III PURPOSE

To provide maximum security for Controlled Substances on ALS units while ensuring that a minimum necessary requirement for Controlled Substances on ALS ambulances are met

IV. POLICY

A. All Advanced Life Support personnel and Advanced Life Support Service Providers are responsible for the security of controlled substances in accordance with this policy.

B. Advanced Life Support Providers shall have a physician in the role of Medical Director. This Medical Director may purchase controlled substances with Drug Enforcement Agency Form 222 from a pharmacy or pharmaceutical supply agency and supply these Controlled Substances to the Advanced Life Support Service Provider.

V. PROCEDURE

A. Supply

1. Each authorized in-service ALS unit shall be stocked with the following controlled substances in the amounts listed:

a. **Morphine sulfate:**

Minimum amount on hand: 20 mg
Maximum amount on hand: 60 mg

AND/OR

b. **Fentanyl:**

Minimum amount on hand: 200mcg
Maximum amount on hand: 400mcg

c. **Midazolam:**

Minimum amount on hand: 20 mg
Maximum amount on hand: 40 mg

OPTIONAL

d. Ketamine:

Minimum amount on hand: 0 mg
Maximum amount on hand: 500 mg

2. ALS Service Providers shall provide written notification to the Agency of the number of units to be stocked with controlled substances.

3. All controlled substances shall be supplied in single-unit dose (tamper-evident, when possible) containers, protected from light, and maintained within the manufacturer suggested temperature range whenever possible. Providers shall address the stocking of single-unit dose tamper evident containers in their Provider Controlled Substance Policy.

B. Storage and Access

1. All controlled substances will always be secured under double lock (two separate locking mechanisms) except when being administered to a patient.

2. Access to keys allowing access to controlled substances shall be limited to the Paramedic assigned to an in-service ALS unit. These keys should be passed from the off-going Paramedic to the on-coming Paramedic when the controlled substance Log entry is completed for that shift change.

    a. At no time shall controlled substance storage box keys be in the possession of off-duty personnel.

    b. A duplicate set of unmarked keys may be kept by the ALS Service Provider. Duplicate keys must be kept in a locked compartment, on company grounds, with access by no more than three (3) management personnel approved by the Agency. A complete list of personnel with access to the duplicate controlled substance keys must be submitted to the Agency. This list must be updated within three (3) days of having someone removed or added to the list.

    c. All controlled substance keys must be engraved "Do Not Duplicate."

    d. If any key which allows access to controlled substances or to the duplicate set(s) of keys is lost or stolen, an Unusual Occurrence Report (UOR) shall be filed with the Agency or his/her designee within 24 hours of discovery. The Agency will evaluate the report and decide the appropriate action necessary to resolve the situation.

3. Electronic locks securing controlled substances shall have a unique code for each Paramedic that accesses the controlled substances. Entry to the controlled substances should have the ability to be tracked for accountability. A complete list of personnel with access to the controlled substance must be maintained by the provider and available to the Agency within a reasonable timeframe. This list must be updated within three (3) days of having someone removed or added to the list.

4. Biometric locks shall have the ability to track entry to controlled substances for accountability. A complete list of personnel with access to the controlled substance must be maintained by the provider and available to the Agency within a reasonable timeframe. This list must be updated within three (3) days of having someone removed or added to the list.

C. Initial ALS Unit Stocking Procedures

1. Controlled substances shall be purchased by the ALS Provider physician Medical Director and assigned to its ALS response vehicles according to Drug Enforcement Agency regulations.

2. The person having the prescription filled and the Paramedic responsible for controlled substances must sign the Controlled Substance Log at the time the prescription is placed in an ALS unit.

D. Resupply of Controlled Substances

1. When a controlled substance is used in the field, resupply shall be provided from the supply provided by the ALS Provider physician Medical Director.

    a. Unused drugs must be wasted in the presence of the Emergency Department Registered Nurse and the ALS personnel seeking resupply. The Registered Nurse and the ALS personnel must co-sign to document the wasting of the unused drugs.

E. Exchange of Controlled Substances

1. Controlled substances, soon to expire controlled substances, or damaged controlled substance containers must be replaced by the ALS Provider physician Medical Director. The broken or outdated drug must be presented to receive a replacement with at least two management staff witnessing this as waste.

2. If damage to a controlled substance container has caused a loss of the substance or the substance is being exchanged due to findings resulting from an examination; a UOR shall be filed with the Agency within twenty-four (24) hours of findings. The Agency will investigate the UOR and report their findings to the ALS provider management and Medical Director.

F. Record Keeping/Shift Change

1. Each ALS unit will maintain a standardized written record of Controlled Substance inventory (Controlled Substance Log) and keep it in the locked storage compartment with the Controlled Substances. The Controlled Substance Log shall be available to the Agency and ALS Provider physician Medical Director for routine inspection and shall be maintained by the ALS Provider for a period of three (3) years in compliance with the State Board of Pharmacy.

2. At each crew change, the off-going Paramedic responsible for Controlled Substances shall count and examine the controlled substance(s) and date, time and sign the Controlled Substance Log over to the on-coming Paramedic responsible for Controlled Substances. The on-coming Paramedic will confirm the count and condition and accept responsibility for the controlled substances by signing the Controlled Substance Log. Signing the Controlled Substance Log confirms that the count and supply listed are correct and accurate at that time. A copy of the Controlled Substance Logs shall be made available to the Agency immediately upon request.

G. Inventory Discrepancies

1. If at any time the controlled substance count is incorrect and the missing substance(s) cannot be accounted for, the Paramedic responsible for controlled substances on that unit shall:

    a. Immediately inform his/her supervisor of the incident.

b. Immediately notify the Agency Duty Officer.

c. File an Unusual Occurrence Report with the Agency within twenty-four (24) hours of findings.

d. Be prohibited from going off duty until their supervisor and the Agency Duty Officer are notified.

H. Removing an ALS Unit from Service

1. The security and responsibility for Controlled Substances on out-of-service and back-up ALS units is as follows:

a. When an ALS unit is taken out-of-service or is being placed on back-up, the Paramedic responsible for controlled substances shall count and examine the controlled substances, enter the date and time, and sign the Controlled Substance Log. The Paramedic must also note on the Controlled Substance Log that the ALS unit is out-of-service or on back-up. A second ALS Provider staff person must also verify the count and accuracy of the Controlled Substance Log. This second person must either be another Paramedic, or a member of the ALS Service Provider's staff that has been approved by the Agency. This staff person must either be the sole resupply person or an assigned administrative staff person for the ALS Service Provider.

b. The controlled substances and the Controlled Substance Log shall be kept in the permanent key locked storage compartment, located in the ALS unit. The outside doors of the ALS unit shall remain locked, while the unit is unattended.

c. The controlled substance keys for that ALS unit shall be kept by the ALS Service Provider staff person as described in H.1.A.

2. Upon request, the Agency may allow ALS Service Providers to utilize alternate procedures than are specified in Section V, Letter D. Alternate procedures shall be written as company policy and must have the written approval of the Agency. The Agency shall have the authority to enforce alternate procedures as Agency policy.

I. Placing an ALS Unit in Service

1. The responsibility of controlled substances on out-of-service and back-up ALS units rests solely with the ALS service providers. ALS service providers are required to have a company policy and procedure that addresses the following:

a. The storage of controlled substances on out-of-service ALS units.

b. The procedure for turning over controlled substance storage compartment and lock box keys to the on-coming crew when the unit has been out-of-service or unstaffed on back-up.

2. If an ALS stocked unit is placed in-service as a BLS unit, the responsibility for the

controlled substances on that unit remains with the ALS Service Provider. The keys which allow access to the controlled substances must remain under the control of the ALS Service management.

3. Current ALS service providers must have their company's Controlled Substance Policy and Procedure on file with and approved by the Agency. Agency staff shall be available to assist ALS providers in establishing company policies that will meet Agency approval.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 11/9/11
SUPERSEDES:
REVISED: 11/2011
REVIEW DATE: 11/2016

EMS AIRCRAFT REQUEST/CANCELLATION

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, Section 1797.220, California Code of Regulations, Title 22., Prehospital Emergency Medical Services, Chapter 8., Prehospital EMS Aircraft Regulations, Title 21, Public Works Chapter 2.5 Division of Aeronautics (Department of Transportation), Public Utilities Code Section 21662.1., and Federal Aviation Regulations

II. DEFINITIONS

Reference the EMS Aircraft Definitions Policy #441.00.

III. PURPOSE

The purpose of this policy is to specify the appropriate procedure to request and/or cancel the dispatch of an EMS aircraft.

IV. POLICY

A. The EMS Agency shall designate a County Air Resource Center (C.A.R.C.) in each county to be the primary coordination point for all EMS Aircraft requests for all field emergencies. Unless otherwise specified, this center shall be the EMS Ground Ambulance Dispatch Center for the county.

B. Each C.A.R.C. shall adopt a plan for requesting EMS aircraft that ensures that they are the primary coordination point for all EMS aircraft field requests in the county.

C. Each C.A.R.C. shall install and utilize EMSystem to track availability of EMS Aircraft.

D. Each C.A.R.C. shall install and utilize a data system to document data requirements of this policy.

E. Requests for EMS aircraft resources may be made:
1. for field emergencies by medical or public safety personnel as identified in Section V (E.1), by contacting the applicable C.A.R.C.; or,
2. for interfacility transfers from personnel at a licensed acute care hospital who shall call directly to the Air Ambulance Dispatch (A.A.D.) of their choice.

F. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft.

1. In the event two air ambulances are co-located or nearly co-located, the C.A.R.C. shall have a policy to rotate calls between those providers which must be approved by the Agency. If closest EMS Aircraft Provider is not available, the C.A.R.C. will request the next closest available provider.

2. If an EMS Aircraft Provider has turned down the flight due to weather considerations, the C.A.R.C. shall notify other EMS Aircraft Providers requested to take the flight that another provider declined to respond based upon weather conditions.

G. The C.A.R.C. shall:

1. maintain a master listing of all Regionally authorized EMS aircraft
2 act as the communication coordination point between responding EMS ground units and the EMS Aircraft responding to the scene of the field emergency
3. maintain records of all EMS Aircraft utilization within its jurisdiction
4. have a method to determine the closest EMS Aircraft Provider to an incident
5. have the capacity and check EMSystem for current updates of the location of all authorized EMS aircraft as they are provided by the air ambulance providers.

H. The C.A.R.C. shall request EMS aircraft dispatch in conjunction with the dispatch of all appropriate first responders and ground ambulances by any of the following methods:

1. Simultaneous Dispatch
2. On Scene Request
3. EMS unit request while en route to an emergency

I. Interfacility transfers utilizing EMS aircraft shall be requested/canceled by physicians or hospital personnel at either of the two acute care facilities initiating and receiving the patient transfer.

V. <u>Procedure</u>

A. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft provider and provide the necessary information as outlined in this policy.

B. The minimum data to be recorded by the C.A.R.C. for each EMS aircraft request shall include:

1. Incident number
2.. date requested
3. time requested
4. agency that requested service
5. agency that canceled service

. 6. estimated time of arrivalof aircraft

C. Required Information for Request of EMS Aircraft

1. The EMS Aircraft shall be requested by the C.A.R.C. as soon as the following essential information is received from the reporting party:
   a. requesting agency
   b. location
   c. number of patients - if known
   d. type of incident
   e. extent of injuries or illness, if known

2. Before completing a call, dispatchers at the C.A.R.C. shall attempt to obtain the following information from individuals/organizations requesting EMS aircraft services and pass the information on to the responding EMS Aircraft.
   a. Landing site information (if possible)
      (1) coordinates
      (2) landmarks identifiable from the air
      (3) designated landing zones
      (4) cross streets
      (5) township
   b. Terrain and obstacles
   c. Weather conditions
      (1) wind direction and speed
      (2) visibility
      (3) temperature
   d. Responding EMS services (air or ground)
      (1) ground frequencies and PLs on which they may be contacted

D. Simultaneous EMS Aircraft Dispatch Criteria

1. C.A.R.C.s or authorized EMS dispatch agencies shall simultaneously dispatch the closest ground ambulance and request that the closest air ambulance respond to those incidents within the simultaneous dispatch zone when the information received from the calling party indicates the incident involves a:

   a. Gun shot wound
   b. Stabbing to head, neck, or torso
   c. Fall greater than 20 feet
   * d. Motorcycle accident
   * e. Auto vs. pedestrian
** * f. Motor vehicle accidents with high speed potential
   g. Explosions
   h. Electrocution
   i. Multi-Casualty Incident
   j. Industrial/Agricultural/Logging Accident with Major Injuries

* Unless low speed and only minor injuries are specified.
** Each county should identify their areas of high speed potential.

E. On Scene Request Criteria

1. An EMS aircraft and ALS ground unit shall be dispatched upon request of any on-scene fire or law enforcement agency, ambulance personnel, other first responders, , clinic, physician's office, or any public safety officer if any of the following conditions are present:

   a. Potential life or limb threatening injuries where transport time to the appropriate medical facility would be significantly reduced by use of the helicopter.
   b. Unavailability of an ALS ground ambulance.
   c. Any other incident where additional ALS assistance is needed.

2. During any scene call in which a medical facility, clinic, or physician's office requests air transport to a destination not consistent with agency policy, the base hospital shall be contacted and approve the destination request.

F. En route Request Criteria

1. Responding emergency personnel that have knowledge of the scene or additional information beyond that provided by the C.A.R.C., may ask that an EMS aircraft be dispatched. After assessing the scene the emergency personnel shall immediately cancel or ask for a continued response by the EMS Aircraft.

G. Cancellation of EMS Aircraft

1. All EMS aircraft cancellations shall be coordinated by the C.A.R.C.
2. Cancellation of EMS aircraft service may occur due to:
   a. Pilot Judgment: The pilot may cancel the mission due to weather conditions or pilot judgment. The Air Ambulance Dispatch shall immediately notify the C.A.R.C. of the reason for cancellation.

      The C.A.R.C. shall request another EMS Aircraft if the reason for cancellation by the original pilot is due to:
      1) lack of pilot's specific knowledge of unsafe conditions at the scene of the emergency
      2) inclement weather en route to the emergency
      3) inclement weather at the EMS Aircraft provider's base of operations

      The C.A.R.C. shall inform the subsequent EMS aircraft provider(s) of the circumstances of the original mission cancellation. The C.A.R.C. shall relay all information concerning the cancellation and/or dispatch of another EMS aircraft to the Incident Commander,

   b. Poor weather conditions at the scene: The C.A.R.C. will not request additional EMS Aircraft if the reason for cancellation is due to inclement weather at the scene of an emergency.

   c. Lack of emergency medical need: The Paramedic, EMT, or recognized first responder working within the EMS system who cancels the assigned EMS aircraft because of lack of medical need shall be on scene and have

knowledge of the patient's medical condition. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and identification of the Air Operations Director, IC, or Medical Group Supervisor.

d. Logistical and/or safety considerations: The Incident Commander (IC) or his designee may cancel the air ambulance when he feels that landing the helicopter would be unsafe, or there is no appropriate landing zone, or there is no patient. Alternate landing zones should be considered. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and IC identification. The C.A.R.C. shall then call the A.A.D. to cancel the air ambulance.

3. C.A.R.C. Dispatchers will cancel an EMS aircraft mission only after documenting:

a. Pilot Judgment: Verify from the pilot the reason for cancellation.
b. Lack of medical need: Verify from the EMS provider the following:

(1) The name of the agency canceling the mission.
(2) Confirm that the agency canceling the mission is on scene.

c. Logistical and/or safety considerations: Verify from the calling party the following information:

(1) The Incident Commander canceling the mission.
(2) The logistical and/or safety consideration why the mission is canceled.
(3) Verification as to whether a medical need still exists.
(4) Alternate landing sites.

WHENEVER THE DISPATCHER CANNOT COMPLETELY VERIFY THAT ALL CRITERIA FOR CANCELLATION ARE MET, THE MISSION WILL NOT BE CANCELED. C.A.R.C. Dispatchers, however, shall notify the A.A.D. of the dispatched EMS Aircraft that an unverified request for cancellation has been received. Cancellation of EMS aircraft will occur only when verified cancellations are obtained.

---END OF POLICY 445.00---

POLICY: 522.20
TITLE: Stroke Triage and Destination

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

STROKE TRIAGE AND DESTINATION

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170, California Code of Regulations, Title 22, Division 9

II DEFINITIONS

A. **ALS** - means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

B. **Comprehensive Stroke Center (CSC)** – refers to a hospital that has received comprehensive status through American Heart Association (AHA) and Joint Commission review as well as local EMS agency designation. CSC sites have availability of advanced imaging techniques including Computed Tomography Angiogram/Perfusion (CTA/CTP), Transcranial Doppler (TCD). These facilities have 24/7 availability of personnel, imaging, operating room and endovascular facilities allowing for the management of large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

C. **Emergency Medical Services (EMS)** - means the services utilized in responding to a medical emergency.

D. **Large Vessel Occlusion (LVO)** – refers to the site of an ischemic clot within the brain leading to stroke symptoms. LVO strokes may benefit from transport to a CSC facility per MCEMSA Stroke Destination Policy.

E. **Last Known Well Time (LKWT)** refers to the time at which the patient was last known to be without signs and symptoms of the current stroke or at their baseline.

F. **MCEMSA** means Mountain Counties EMS Agency.

G. **MCEMSA Stroke Criteria** - means a patient stroke assessment using the VAN (vision, aphasia, neglect) assessment resulting in a positive finding.

H. **Primary Stroke Center (PSC)** - means a hospital designated to stabilize and treat acute stroke patients, providing initial acute care. PSCs are able to appropriately use thrombolytics and other acute therapies such as stabilizations of vital functions, provision of neuroimaging procedures, and management of intracranial and blood pressures. Based on patient needs and the hospital's capabilities, they either admit patients or transfer them to a comprehensive stroke center.

I. **Quality Improvement (QI)** - means a method of evaluation of services provided, which includes defined standards, evaluation methodologies and utilization of evaluation results for continued system improvement. Such methods may include, but are not limited to, a written plan describing the program objectives, organizations, scope and mechanisms for overseeing the effectiveness of the program.

J. **Stroke** - means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction.

K. **Stroke Alert** - means a notification from the transporting ground or air ambulance to a PSC or CSC that a patient meeting MCEMSA Stroke criteria is being transported to their facility. A Stroke Alert must be made as soon as possible after stroke criteria is confirmed.

L. **VAN (vision, aphasia, neglect) Assessment** - means a prehospital screening tool used to identify the presence of large vessel occlusive stroke. The patient is deemed to have a positive VAN assessment with any arm weakness and at least one of the following: vision change, aphasia or neglect on exam. A VAN negative exam is either no arm muscle weakness OR the presence of arm muscle weakness without vision, aphasia or neglect findings.

III PURPOSE

To rapidly identify suspected acute stroke patients, provide treatment and prompt transport, to the appropriate Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) for rapid evaluation and treatment.

IV. POLICY

A. STROKE SYSTEM TRIAGE

1. Appropriate triage of the suspected acute stroke patient using stroke alert criteria relies on rapid prehospital care:

   a. Recognition of signs and symptoms of stroke using VAN assessment for LVO.

   b. Determination of time last known well without stroke symptoms within the past 24 hours by a reliable historian.

   c. Complete Fibrinolytic Checklist.

2. Stroke Alert notification to PSC or CSC to report positive stroke assessment findings.

B. DESTINATION

1. Suspected acute stroke patients shall be transported to the appropriate PSC or CSC within the following parameters:

   a. If the patient is found to be **VAN positive,** the patient may be transported directly to a CSC if the following criteria are met:

      i. Last known well time is within 24 hrs.

      ii. Transport time to the CSC will not exceed 60 minutes.

      iii. Transport time will not take the patient out of the 4.5-hour window for thrombolytic therapy from onset of symptoms or LKWT.

      iv. No "comfort measures only" POLST.

b. If the patient is found to be **VAN negative**, the following transport criteria shall be followed:

i. If the patient does not have a preference, the patient shall be transported to the nearest PSC or CSC

ii. If transport to a PSC or CSC is estimated to be greater than twenty (20) minutes, the patient shall be transported to the nearest ED facility capable of receiving stroke patients.

iii. All emergency departments can receive stroke patients.

c. Paramedics in MCEMSA should exercise their judgment and request air transport (if available) for stroke patients to a PSC or CSC.

d. Unstable stroke patients shall be transported to the closest emergency department. Unstable stroke patients are defined as any ONE of the following:

i. Patients undergoing CPR or with rapidly deteriorating vitals signs where CPR will likely be initiated during transport.

ii. Inability to ventilate and/or oxygenate the patient using a bag valve mask with a BLS airway adjunct.or advanced airway.

2. A PSC/CSC may request advisory status through the EMS Duty Officer for incoming stroke patients only when:

a. The PSC/CSC is on internal disaster; or

b. Inoperable CT/MRI.

3. Patients should be taken directly to the CT scanner.

a. The patient is to remain on cardiac monitor if taken directly to the CT. The patient will remain on the cardiac monitor until Paramedic transfers patient care.

b. Paramedic will give report to the nurse transfer patient directly from gurney to CT scanner platform and return to service.

c. If there is any delay, such as CT scanner not being readily available, the paramedic will not be expected to wait. The patient will be taken to a monitored bed and report given to a receiving nurse or physician as is customary.

C. STROKE ALERT/PATIENT REPORT

1. As soon as a suspected LVO stroke patient is confirmed with the VAN assessments, the appropriate destination shall be determined, and a Stroke Alert promptly communicated to the PSC/CSC and/or the closest receiving facility. The Stroke Alert is to contain the following information:

a. Identify the call as a “Stroke Alert” and verify CT operability.

b. Provide estimated time of arrival (ETA).

c. Patient’s age and gender.

d. Give time patient was last seen without stroke symptoms (Last Known Well Time).

e. VAN assessment result-negative or positive.

f. Blood Glucose and Vital Signs.

g. Treatment and response to treatment.

h. Contraindications to fibrinolytic therapy.

2. Electronic Patient Care Report(ePCR) documentation must include:

a. Last known well time
b. VAN assessment results,

c. Blood glucose check

d. Neurological assessments

e. Factors that determined patient destination

POLICY: 530.00
TITLE: STEMI Triage and Destination

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

STEMI TRIAGE AND DESTINATION

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170

II. DEFINITIONS

A. **ST-elevation myocardial infarction STEMI** is a clinical syndrome of an acute myocardial infarction meeting STEMI criteria on a 12-lead ECG.

B. **STEMI Alert** is a report from prehospital personnel that notifies a STEMI Receiving Center or STEMI Referral Hospital as early as possible that a patient has a specific computer-interpreted Prehospital 12-lead ECG indicating a STEMI.

C. **STEMI Receiving Center** (SRC) is a that has an interventional cardiology lab licensed by the Department of Health Services and approved by the local EMS agency which provides emergent cardiac catheterization 24 hours a day, 7 days a week, 365 days a year, with an established quality assurance program and a written commitment by the hospital administration supporting the center's interventional cardiology mission for STEMI patients.

D. **STEMI Referral Hospital (SRH)** is any hospital in the Mountain Counties EMS Agency region that lacks the availability or continuous availability of 24/7/365 cardiac catheterization. These hospitals will have the ability to administer thrombolytics to a STEMI patient. These hospitals will also have written transfer policies for STEMI patients to STEMI Receiving Centers.

E. **STEMI Patient** means a patient 18 years of age or greater who has received a 12 lead electrocardiogram in the pre-hospital environment that stipulates ***Acute MI Suspected*** or "ECG Suggestive of Acute MI" or "STEMI" on the computer interpretation on the ECG.

F. **Pre-Hospital Care Provider** means the ambulance service provider, fire service agency, or any other emergency service provider authorized by Mountain Counties EMS Agency.

G. **ALS** means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

III. PURPOSE

To establish guidelines for prehospital personnel to identify and transport patients with acute ST-Elevation Myocardial Infarction (STEMI) who may benefit from the rapid response and specialized services of a STEMI Receiving Center (SRC) without prior base hospital authorization.

IV. POLICY

This policy applies to adult patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) with a 12-lead ECG demonstrating elevated ST-segments indicating a specific type of myocardial infarction.

V. TRIAGE

A. All STEMI patients within MCEMSA shall be assessed and treated by pre-hospital personnel in accordance with the Mountain Counties EMS treatment guidelines.

B. Patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) shall have a 12-lead ECG performed.

1. 12-lead ECGs showing suspected STEMI will be transmitted to the SRC by pre-hospital care providers 12-lead ECG transmission device if capable..

2. Exceptions include patients who are not cooperative with the procedure or patients in whom the need for critical resuscitative measures preclude performance of 12-lead ECG.

3. Paramedic shall review the 12-lead ECG tracing in all instances to assure that little or no artifact exists (steady baseline, lack of other electrical interference, complete complexes present in all 12 leads). Repeat ECG may be necessary to obtain an accurate tracing.

C. If computerized interpretation of accurately performed 12-lead ECG indicates either ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***, the patient qualifies as a candidate for transport to a STEMI Receiving Center. Patients without these findings shall be transported per MCEMSA Policy 511.00.

Note: Hypotensive STEMI patients should be transported to the closest ED.

VI. DESTINATION

A. A patient with an identified STEMI should be transported to the designated STEMI Receiving Center with the quickest ETA if estimated transport time is sixty (60) minutes or less, bypassing all other receiving facilities.

B. In cases where there is no SRC within 60 minutes, the patient shall be transported to the nearest STEMI Referral Hospital. Paramedics in MCEMSA should exercise their judgment and, in communication with the base hospital, request air medical transport (if available) of STEMI patients to a SRC if air transport improves ETA at the SRC.

C. If ETA is greater than 60 minutes to a SRC, complete Fibrinolytic Checklist. If patient has contraindications to fibrinolytics, contact base hospital for destination.

D. Unstable STEMI patients shall be transported to the nearest emergency department. Unstable STEMI patients are defined as any ONE of the following:

1. Patients undergoing CPR or with rapidly deteriorating vital signs that indicate that CPR will likely be initiated during transport.

2. Inability to ventilate and/or oxygenate the patient via BVM with BLS airway adjunct or advanced airway.

E. A STEMI Receiving Center may request advisory status for incoming STEMI patients only when:

1. The STEMI Receiving Center is on internal disaster; or

2. The Cardiac Catheterization laboratory is closed for repair or upgrade.

VII. STEMI ALERT/PATIENT REPORT

A. The STEMI Alert should contain the following information:

1. Situation:

a. Identification of the call as a "STEMI Alert."

b. Estimated time of arrival in _____ minutes for STEMI.

c. Patient age and gender

d. Confirm ECG states ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***

e. If patient elects to go to a facility that is not a STEMI Receiving Center

f. Any urgent patient concerns

2. Background:

a. Patient presenting complaint including any duration and presence/absence of chest pain, pressure, jaw pain, or SOB.

b. Pertinent past cardiac history including presence of a pacemaker

c. Any contraindications to fibrolytic therapy.

3. Assessment:

a. General Impression

b. Patient improved or worse since on scene

c. Pertinent vital signs and significant abnormal physical examination findings

4. Treatment:

    a. Prehospital treatment given and response to treatment.

    b. If able without creating transportation delay, transmit the ECG to receiving facility as soon as possible.

VIII. DOCUMENTATION

A. A copy of the 12-lead ECG shall be delivered to the nurse or doctor caring for the patient at arrival in the Emergency Department

B. A copy of the 12-lead ECG shall be generated for inclusion in the Prehospital Patient Care Report (PCR) or incorporated via electronic means into the record. The finding of STEMI on 12-lead ECG and confirmation of the STEMI Alert shall also be documented on the PCR.

POLICY: 552.10
TITLE: Local Optional, EMT Draw Up Epinephrine

EFFECTIVE: 10/17/2025
REVIEW: 10/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

LOCAL OPTIONAL, EMT DRAW UP EPINEPHRINE

I. AUTHORITY

Division2.5, California Health and Safety Code, Sections 1797.172, 1797.185, 1797.206, 1797.214, 1797.218, 1797.220, and 1797.221. Title 22, California Code of Regulations, Sections 100064.

II. DEFINITIONS

A. **Agency or LEMSA** means Mountain Counties Emergency Medical Services Agency.

B. **Emergency Medical Technician or EMT** means an individual that has successfully completed a basic EMT course that meets the requirements of Title 22; California Code of Regulations, Chapter 3, has passed all required exams, and who has been certified by the Agency Medical Director as an EMT.

C. **Local Accreditation or accreditation or accredited to practice** means authorization by the Agency to practice the optional skill(s) approved by the Agency. Such authorization ensures the EMT has been oriented to the LEMSA and trained in the optional skill(s) to achieve the standard of treatment approved by the Agency.

D. **Optional Scope of Practice Provider Agency** means any first responder agency that has entered into an agreement with the Agency to provide EMT optional scope of practice medications and/or procedures.

III. PURPOSE

A. To assist our providers in controlling costs, this policy will allow for EMT use of draw up Epinephrine within the Agency jurisdiction in place of Epi Pen Auto Injectors.

B. To define criteria for EMT authorization and administration of Intramuscular (IM) injection of Epinephrine, 1:1000 concentration, in cases of severe asthma and anaphylaxis.

C. This is an optional skill for EMS Providers to adopt.

IV. POLICY

As part of the State approved optional scope of practice and in accordance with Agency policies and treatment protocols, a supervised EMT student or a certified EMT, is authorized during training, while at scene of an emergency, during transport of a sick or injured or during an inter-facility transfer to administer IM injection of Epinephrine, 1:1,000 concentration, in cases of anaphylaxis and severe asthma.

A. Any Provider Agency wishing to administer IM injection of Epinephrine within the Agency shall meet the following requirements.

1. Provider shall be approved by the Agency prior to beginning service. The following shall be submitted to receive and maintain IM Epinephrine provider approval.
    a. A written request to the Agency for the use of EMT Draw up Epinephrine optional skill including:
        i. Name(s) and qualifications of the individual overseeing the EMT epinephrine draw up program for the provider agency.
        ii. Roster of EMTs accredited to administer IM epinephrine.
        iii. Copy of documentation to ensure maintenance of epinephrine, per manufacturer recommendations, including expiration dates.
        iv. Documented process used for continued competency of IM injections of Epinephrine.
        v. Procedure for submission of data and prehospital care reports (PCRs) to the Agency for **ALL** EMT epinephrine draw up administrations.
        vi. EMT epinephrine draw-up Quality Improvement Plan that meets or exceeds requirements under MCEMSA #620.10 Quality Improvement Plan. The plan shall include a policy and procedure to collect, maintain, and evaluate patient care records including 100% review for all EMT administrations of draw up epinephrine.
        vii. Upon receipt, application materials will be reviewed for completeness. If any required documentation is missing, the applicant will be notified, in writing, withing fourteen (14) business days. Missing information shall be submitted within thirty (30) calendar days. Failure to submit missing information within thirty (30) calendar days will require the provider to reapply.
        viii. Upon receipt, the application materials will be reviewed for completeness. The provider will receive written notification withing thirty (30) calendar days of request for EMT optional skills approval.

B. Optional Scope of Practice Provider Agencies must be an authorized or use an approved training provider. Training curriculum shall be approved by the LEMSA.

C. Training in the administration of IM epinephrine shall be no less than two (2) hours and contain the following topics and skills:

1. Managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms and the common causative agents.
2. Assessment Findings
3. Appropriate personal protective equipment and scene safety awareness
4. Profile of epinephrine, including but not limited to:
    a. Names
    b. Indications
    c. Contraindications
    d. Side/adverse effects
    e. Interactions
    f. Routes of administration by auto-injector, prefilled syringe, and drawing up the proper drug dose into a syringe.
    g. Calculating dosages
    h. Mechanisms of drug action
5. Medical Asepsis technique.
6. Disposal of contaminated items and sharps.

D. At the completion of this training, the EMT shall complete a competency-based written and skills examination which shall include:

1. Assessment of when to administer epinephrine.
2. Managing a patient before and after administration of epinephrine.
3. Using universal precautions and body substance isolation procedures during medication administration.
4. Demonstrating aseptic technique during medication administration.
5. Demonstrating preparation and administration of epinephrine by auto-injector, prefilled syringe and drawing up the proper drug dose into a syringe.
6. Demonstrating proper disposal of contaminated items and sharps.

E. EMT's trained and accredited to administer shall demonstrate competency to an approved training officer at least every two (2) years, or more frequently as determined by the Agency. The demonstration may be simulated or during patient care.

F. EMT's may use the epinephrine draw-up optional skill as long as EMT certificate is active and while on-duty with, and employed by, the EMS provider who is approved by the agency to provide the epinephrine draw up skill.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 2/1998
SUPERSEDES:
REVISED: 8/2007
REVIEW DATE: 8/2012

INTRAVENOUS INFUSIONS OF HEPARIN & NITROGLYCERIN

I. AUTHORITY: Health and Safety Code, Division 2.5,
California Code of Regulations, Title 22, Division 9

II. PURPOSE: To provide a mechanism for EMT-Ps to monitor intravenous infusions of heparin and nitroglycerine during interfacility transfers

I. POLICY:

A. Only those EMT-Ps who have successfully completed training program(s) approved by the Mountain-Valley EMS Agency Medical Director on nitroglycerin and heparin infusions will be permitted to monitor them during interfacility transports.

B. Only those ALS ambulance providers approved by the Mountain-Valley EMS Agency Medical Director will be permitted to provide the service of monitoring nitroglycerin and/or heparin infusions during interfacility transports, from approved hospital(s) within their service area.

IV. PROCEDURE:

A. PRIOR TO TRANSFER:

1. Patients that are candidates for paramedic transport will have pre-existing heparin and/or nitroglycerin drips in peripheral lines only.

2. Heparin and nitroglycerin drips will not be initiated immediately prior to transport.

3. Patients will have maintained stable vital signs for a period of time as determined by the transferring physician.

4. Patients will not have more than two medicated drips running, exclusive of potassium chloride (KCl).

5. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the EMT-P.

6. Transferring physicians must be aware of the general scope of practice of paramedics and the transport protocol parameters outlined below.

7. EMT-Ps are allowed to transport patients on heparin and nitroglycerin drips within the following parameters:

a. Nitrogycerin

(1) Infusion fluid will be D5W or NS. Medication concentration will be either 25 mg/ 250 cc or 50 mg/250 cc.

(2) Physician orders regarding regulation of the drip rate will be within parameters as defined by the transferring physician, but in no case will changes be in greater than 5 mcg/minute increments every 10 minutes. In cases of severe hypotension, the orders should state that the nitroglycerine drip will be discontinued and the transferring hospital and base hospital is to be notified.

(3) Absolute drip rates will not exceed 100 mcg/minute.

b. Heparin

(1) Infusion fluid will be D5W or NS. Medication concentration will be 100 U/cc of IV fluid (25,000 U/ 250cc).

(2) Drip rates will remain constant during transport. No regulation of the rate will be performed, except to turn off the infusion completely.

(3) Drip rates will not exceed 1600 U/hour.

8 Patients will meet pre-established hospital criteria for hemodynamic stability.

9. The transferring physician or nurse on shall complete a "Heparin-Nitroglycerin Paramedic Transfer Checksheet," which identifies the hemodynamic criterion utilized, and that all criteria for transfers as outlined in this section have been met.

10. Signed orders from the transferring physician will be obtained prior to transport and reviewed with the transporting paramedic(s).

B. DURING TRANSPORT

1. Heparin and nitroglycerin drips will <u>not</u> be initiated by prehospital personnel

2. All patients will be maintained on a cardiac monitor and a non-invasive blood pressure monitor that will record blood pressure readings every five (5) minutes.

3. If medication administration is interrupted (infiltration, accidental disconnection, malfunctioning pump, etc.), the EMT-P may restart the line as delineated in the transfer orders.

4. In cases of IV pump malfunction that cannot be corrected, the medication drip will be discontinued and the transferring hospital and base hospital will be notified.

5. In cases of severe hypotension, nitroglycerin drips will be discontinued and the transferring hospital and base hospital is to be notified

6 Vital signs will be monitored and documented every 5 minutes.

7 No other medication shall be given thru the same line.

C. All calls will be audited by the ambulance provider agency and by the transferring hospitals. Audits will assess compliance with physician orders and regional protocols, including base hospital contact in emergency situations. Reports will be sent to the EMS Agency as requested.

POLICY: 552.66
TITLE: Optional Scope: EMT, AEMT, and Paramedic Administration of Influenza Vaccine

EFFECTIVE: 10/17/2025
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

AEMT/PARAMEDIC ADMINISTRATION OF INFLUENZA VACCINE

I. AUTHORITY:
Health and Safety Code, Division 2.5, Section 1797.172, 1797.220, 1797.214, California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100145

II. DEFINITIONS

III. PURPOSE:

To authorize AEMT, and Paramedics to administer intramuscular inactivated influenza vaccine to adult patient populations (14 or older) during organized vaccine clinics. These vaccination policies and procedures shall only be authorized and valid for AEMTs, and Paramedics accredited in Local EMS Agencies (LEMSAs) that have been approved to utilize this local optional scope of practice.

IV. POLICY
AEMTs, and Paramedics accredited in LEMSAs approved for this local optional scope of practice may provide influenza vaccinations to persons as directed by the LEMSA in conjunction with the County Public Health Department after completing required training.

V. VACCINE ADMINISTRATION PROCEDURE

A. Assess the need and eligibility for the vaccine utilizing the current guidance provided by the LEMSA and/or the County Public Health Dept. (also see CDC information regarding the seasonal flu vaccine https://www.cdc.gov/flu/prevent/keyfacts.htm)
B. Screen for contraindications and precautions of inactivated vaccine (listed below).
C. Collect and review pre-vaccination paperwork prior to vaccination:
    1. Signed Vaccine Consent
    2. Record of Administration sheet
    3. Vaccine screening questionnaire
D. To prevent syncope, vaccinate patients while they are seated or lying down.
E. Maintain aseptic technique when administering vaccines.
F. Equipment required:
    1. Vaccine
    2. 23-25 g, 1-inch needle
        i. For larger patients, 1.5-inch needle length may be more appropriate.
        ii. See “Needle Gauge/Length and Injection Site Guidance” below for Additional information.
        iii. Vaccine may come as prefilled/ready to administer or require
        iv. other injection supplies or sizes.
G. Wash hands and don gloves.

H. Check expiration date of vaccine.
I. Prepare vial per manufacturer recommendation
J. Cleanse the area of the deltoid muscle with alcohol prep.
    1. Deltoid landmarks: 2-3 finger widths down from the acromion process; bottom edge is an imaginary line drawn from axilla.
K. Insert the needle at a 90-degree angle into the muscle.
    1. Pulling back on the plunger prior to injection is not necessary.
L. Inject the vaccine into the muscle.
M. Withdraw the needle, and using the alcohol prep, apply slight pressure to the injection site.
N. Do not recap or detach needle from syringe. All used syringes/needles should be placed in puncture-proof containers immediately.
O. Monitor the patient for any symptoms of allergic reaction for time recommended by vaccine manufacturer.
P. Document the following information:
    1. Date of vaccination
    2. Name of patient
    3. Patients date of birth
    4. Gender
    5. Race/Ethnicity
    6. Injection site
    7. Vaccine lot number
    8. Vaccine manufacturer
    9. No contraindications
Q. Complete appropriate documentation:
    1. Vaccine Consent/Record of Administration form: ensure this is completed, retained and appropriately submitted after administration.
        i. Note that medical records/charts should be documented and retained in accordance with applicable state laws and regulations. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal). Discuss the need for vaccine with the patient or legal guardian.
    2. Vaccine Information Statement: document the publication date and the date it was given to the patient.
    3. Patient's medical record: if accessible, record vaccine information (above) in the patient's medical record.
    4. Personal immunization record card: record the date of vaccination and name/location of administering clinic.
    5. Immunization Information System (IIS), or "registry": Report the vaccination to the appropriate state/local IIS, if available.
    6. VAERS: report all adverse events following the administration of a vaccine to the federal Vaccine Adverse Event Reporting System (VAERS).
        ii. To submit a VAERS report online (preferred) or to download a writable PDF form, gotohttps://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.
R. Give patient vaccine information sheet, using the appropriately translated sheet for non-English speaking client; these can be found at www.immunize.org/vis.
S. Advise patient when to return for subsequent vaccination and schedule appointment, if appropriate.

VI. Contraindications, Precautions and Considerations for Vaccine Administration

Contraindications for Vaccines

1. Do not administer vaccines to a person who has an allergic reaction or a serious systemic or anaphylactic reaction to a prior dose of that vaccine or to any of its components. For a list of vaccine components, refer to guidance specific to this vaccine provided by the manufacturer. The manufacturer's package insert contains a list of ingredients (www.immunize.org/fda) and these are also listed at

www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf. Contraindications for Live Attenuated Vaccines are not pertinent as these are not being administered under this local optional scope of practice.

Precautions for use of vaccines – refer to physician

1. Moderate or severe acute illness with or without fever. History of Guillain-Barré syndrome within 6 weeks of a previous vaccination. People with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine (IIV, RIV4, or LAIV4). People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions. Two completely egg-free (ovalbumin-free) flu vaccine options are available: quadrivalent recombinant vaccine and quadrivalent cell-based vaccine.

Considerations

1. Be Prepared to manage medical emergencies:
   Be prepared for management of a medical emergency related to the administration of vaccine by having a written emergency medical protocol available, as well as equipment and medications. Follow local procedures in response to medical emergencies.
2. For the immunization Action Coalition's (IAC) "Medical Management of Vaccine Reactions in Adults in a Community Setting,"
   Go To www.immunize.org/catg.d/p3082.pdf.
3. For IAC's "Medical Management of Vaccine Reactions in Children and Teens in a Community Setting," go to www.immunize.org/catg.d/p3082a.pdf.

Gender, age, weight of patient	Needle Gauge	Needle Length (inches)	Injection Site
11-18 years	22-25	5/8 – 1 1 – 1 ½	Deltoid muscle of arm Anterolateral thigh muscle
Female or male less than 130 lbs	22-25	5⁄8*–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22-25	1"	Deltoid muscle of arm
Female 153–200 lbs	22-25	1–1 1⁄2"	Deltoid muscle of arm
Male 153–260 lbs	22-25	1–1 1⁄2"	Deltoid muscle of arm
Female 200+ lbs	22-25	1 1⁄2"	Deltoid muscle of arm
Male 260+ lbs	22-25	1 1⁄2"	Deltoid muscle of arm

* A 5⁄8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle with the skin is stretched tight, the subcutaneous tissue not bunched, and at a 90-degree angle to the skin, although specific differences may be required by various manufacturers.

POLICY: 552.67
TITLE: Optional Scope, Calcium Channel Blocker Infusion for IFT

EFFECTIVE: 1/1/2026
REVIEW: 1/1/28
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

OPTIONAL SCOPE CALCIUM CHANNEL BLOCKERS FOR IFT

I. AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220, California Code of Regulations, Title 22, Division 9.

II. DEFINITIONS:

A. **Approved Training** means indications, contraindications, actions, adverse effects, appropriate documentation with both written and skills testing required demonstrating basic competency in administration of medication.

B. **Calcium Channel Blockers (CCB)** means medications to include, but are not limited to, Cardizem, Nicardipine, Nifedipine, Clevidipine.

C. **Local Optional Scope of Practice (LOSOP)** means the ability to perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use by the medical director of the LEMSA, that have been approved by California EMSA.

III. PURPOSE
To authorize Paramedics to provide monitoring and titration of Calcium Channel Blocker medication infusions during interfacility transports.

IV. POLICY
A. Only those paramedics who have successfully completed the approved training by the Mountain Counties EMS Agency Medical Director will be permitted to provide the service of monitoring the LOSOP medications.
B. Only those ALS ambulance providers approved by the Mountain Counties EMS Agency will be permitted to provide the service of administering and /or monitoring of LOSOP medications.

V. PROCEDURE
A. Candidates for paramedic transport will have pre-existing medication infusion of approved LOSOP CCB in peripheral IV lines initiated a minimum of 10 minutes prior to transport.

B. Paramedic may **NOT** initiate CCB LOSOP medication infusions.

C. Paramedic shall receive the transferring orders from the transferring physician prior to leaving the sending hospital. Included in the transfer orders shall be a telephone number where the transferring and/or base hospital physician can be reached during transport. Transferring physicians must be aware of the general scope of practice of paramedics.

D. Paramedics are permitted to monitor and adjust infusions as indicated by transferring base

hospital physician. Written orders **MUST INCLUDE** the infusion rate on transfer paperwork.

E. All patients will be maintained and monitored via cardiac monitor and non-invasive blood pressure monitor.

1. Vital signs will be monitored and documented every five (5) to fifteen (15) minutes as specified by transferring physician order and immediately if there is any change in patient status.

F. Regulation of infusion rate will be within the parameters defined by the transferring physician.
1. Infusions must be run through an IV pump or Volutrol.
2. No other product may be infused in the same IV during administration.
3. After infusion is completed, flush the line with NS.

G. Discontinue and notify base physician if allergic reaction or anaphylaxis occur. Treat allergic reaction/anaphylaxis per Treatment Guidelines.

VI. CONTINOUS QUALITY IMPROVEMENT

A. All calls will be audited by the provider agency QI process. Audits will assess compliance with MCEMSA policies, including base hospital contact in emergency situations. Reports will be sent to MCEMSA as requested.

POLICY: 552.68
TITLE: Optional Scope, Norepinephrine Infusion for Interfacility Transport

EFFECTIVE: 1/1/2026
REVIEW: 1/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

OPTIONAL SCOPE, NOREPINEHRINE INFUSION FOR INTERFACILITY TRANSPORT

I. AUTHORITY:
Division 2.5 Health and Safety Code, Section 1797.220 California Code of Regulations, Title 22, Chapter 3.3, Article 2, Section 100091.01

II. DEFINITIONS

A. **Approved Training** means indications, contraindications, actions, adverse effects, appropriate documentation with both written and skills testing required demonstrating basic competency in administration of medication.

B. **Local Optional Scope of Practice** means the ability to perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use by the medical director of the LEMSA, that have been approved by California EMSA.

III. PURPOSE
To authorize the paramedics to administer Norepinephrine and to monitor and adjust existing LOSOP medication infusions during interfacility transports.

IV. POLICY
A. Only those paramedics who have successfully completed the approved training by the Mountain Counties EMS Agency Medical Director will be permitted to provide the service of monitoring the LOSOP medications.

B. Only those ALS ambulance providers approved by the Mountain Counties EMS Agency will be permitted to provide the service of administering and /or monitoring of LOSOP medications.

V. PROCEDURE
A. Candidates for paramedic transport will have pre-existing medication infusion of approved LOSOP Norepinephrine in peripheral IV lines initiated a minimum of 10 minutes prior to transport.

B. Paramedic may **NOT** initiate Norepinephrine LOSOP medication infusions.

C. Paramedic shall receive the transferring orders from the transferring physician prior to

leaving the sending hospital. Included in the transfer orders shall be a telephone number where the transferring and/or base hospital physician can be reached during transport. Transferring physicians must be aware of the general scope of practice of paramedics.

D. Paramedics are permitted to monitor and adjust infusions as indicated by transferring base hospital physician. Written orders **MUST INCLUDE** the infusion rate on transfer paperwork.

E. All patients will be maintained and monitored via cardiac monitor and non-invasive blood pressure monitor.

1. Vital signs will be monitored and documented every five (5) to fifteen (15) minutes as specified by transferring physician order and immediately if there is any change in patient status.

F. Regulation of infusion rate will be within the parameters defined by the transferring physician.
1. Infusions must be run through an IV pump or Volutrol.
2. No other product may be infused in the same IV during administration.
3. After the infusion is completed, flush the line with NS.

G. Discontinue and notify base physician if allergic reaction or anaphylaxis occur. Treat allergic reaction/anaphylaxis per Treatment Guidelines.

VI. CONTINOUS QUALITY IMPROVEMENT

A. All calls will be audited by the provider agency QI process. Audits will assess compliance with MCEMSA policies, including base hospital contact in emergency situations. Reports will be sent to MCEMSA as requested.

POLICY: 553.25
TITLE: Trauma/Burn Triage & Patient Destination

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Trauma/Burn Triage & Patient Destination

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.222, 1798.162, 1798.163
California Code of Regulations Section 100255

II DEFINITIONS

A. **Pediatric or pediatric patient** means an individual age 14 and under.

B. **Pediatric Trauma Center** means a designated facility identified by the Mountain Counties EMS Agency) to receive pediatric trauma patients directly from the field, including:

1. UC Davis Medical Center (Level I)
2. UCSF Benioff Children's Hospital, Oakland (Level I)
3. Renown Children's Hospital, Reno Nevada (Level II)
4. Valley Children's Hospital, Madera (Level II)

C. **Trauma Center** means a licensed hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations, which has been designated as a Level I, II, II or IV trauma center or as a Level I or II pediatric trauma center identified by the Mountain Counties EMS Agency (MCEMSA)to receive trauma patients directly from the field, including:

1. Doctors Medical Center (Level II)
2. Memorial Medical Center, Modesto (Level II)
3. "Trauma Centers" may be designated by other Local EMS Agencies and in some cases, may be the closer facility. If this is the case, trauma patients may be transported directly from the field, these include:

i. UC Davis Medical Center (Level I)
ii. Mercy San Juan (Level II)
iii. Sutter Roseville (Level II)
iv. Kaiser South Sacramento (Level II)
v. Renown Regional Medical Center (Level II)
vi. San Joaquin General (Level II)

D. **Trauma** means physical injury or wound caused by significant external force, high-

energy exchange, a rapid deceleration, or violence.

E. **Trauma Triage criteria** means a guideline for assessing the severity of a person's potential injuries that is used to direct transportation of trauma patients to the appropriate Trauma Center.

F. **Base Hospital** means a hospital approved and designated by the Agency to provide immediate medical direction and supervision of EMT, AEMT, and paramedic personnel in accordance with policies and procedures established by the Agency as defined in MCEMSA Policy number 506.00.

G. **Burn Center** means an intensive care unit in which there are specially trained physicians, physician assistants (PA), nurse practitioners (NP), nursing and supportive personnel and the necessary monitoring and therapeutic equipment needed to provide specialized medical and nursing care to burned patients. including UC Davis and Community Regional Medical Center, Fresno.

III PURPOSE

A. To establish guidelines for identifying trauma patients and for determining their destination.

B. To ensure appropriate utilization of resources within the Mountain Counties EMS system.

IV. POLICY

This policy shall serve to identify patients who are at risk for severe injury and determines the most appropriate destination for transport.

V. PROCEDURE

A. Prehospital EMS Personnel SHALL notify the Base Hospital **IMMEDIATELY** when it is determined that the patient meets trauma triage criteria to advise the Base Hospital. This notification does not have to originate from the person actually caring for the patient but may come from another member of the patient care team.

1. Base Hospital notification SHALL include:
    a. age
    b. mechanism
    c. trauma triage criteria
    d. ETA

3. A full Base Hospital report to the destination Trauma Center from the pre-hospital provider should be made after transport has been initiated in order to assist the Trauma Center in determining appropriate levels of trauma team activation.

B. Triage Upgrade

A patient's triage status may always be upgraded if the patient's condition deteriorates during assessment or transport. A patient's triage status shall not be downgraded by a nurse or paramedic.

C. Destination Decisions

1. All injured patients (Adult & Pediatric) meeting trauma triage criteria shall be transported by the quickest, most appropriate means, ground or air.

   a. If a trauma patient meeting criteria is to be transported by air and environmental conditions do not allow for an air transport, a ground ambulance shall transport to the closest Level I or Level II Trauma Center bypassing all other receiving facilities unless the patient has a life-threatening condition that overrides the need for expedient surgery. In these cases, trauma patients should be transported to the closest facility. This includes, but is not limited to, conditions such as:

      i. Obstructed airways

      ii. Any patient with CPR in progress or with rapidly deteriorating vital signs that CPR will likely be initiated during transport.

      iii. Tension pneumothorax which has not been relieved or stabilized in the prehospital setting, or

      iv. Inability to ventilate patient via bag valve mask with BLS airway adjunct or advanced airway if placed.

      v. Situations where the patient meets criteria as outlined in policy 570.20 “Determination of Death”. Such patients should be transported to the closest appropriate receiving facility or pronounced dead in the field if they meet the criteria outlined in policy 570.20.

   b. Pediatric patients meeting criteria to be transported to a Pediatric Trauma Center shall be transported by air ambulance if the environmental conditions allow. If air resources are unavailable and/or patient is not stable for transport to a Pediatric Trauma Center, transport to the closest adult Level I or II Trauma Center is acceptable.

2. If a Trauma Center is on Trauma Bypass, trauma patients will be transported to the next closest available Level I or Level II Trauma Center as directed by the Base Hospital.

3. Any disputes regarding distribution of patients should be documented on an Unusual Occurrence Report and faxed or electronically transmitted to MCEMSA within 72 hours for review.

D. Burn Triage Criteria:

1. A patient (adult or pediatric) whose primary injuries are burns may be transported directly to a Burn Center from the field. These injuries include:

a. Partial/full thickness (2nd or 3rd degree) burns involving greater than 15% total body surface area (TBSA) without airway compromise.

b. Patients with partial/full thickness (2nd or 3rd degree) burns greater than 10% TBSA without airway compromise with the following:

i. Greater than 60 years of age

ii. Associated trauma meeting Trauma Triage Criteria (and if transport can be completed within 60 minutes)

iii. Significant co-morbidities (including but not limited to COPD, cardiac condition, poorly controlled diabetes, bleeding disorder or anticoagulant therapy, dialysis patients)

c. Partial/full thickness (2nd or 3rd degree) burns of face, hands, feet, major joints, genitals, perineum or circumferential burn to any body part

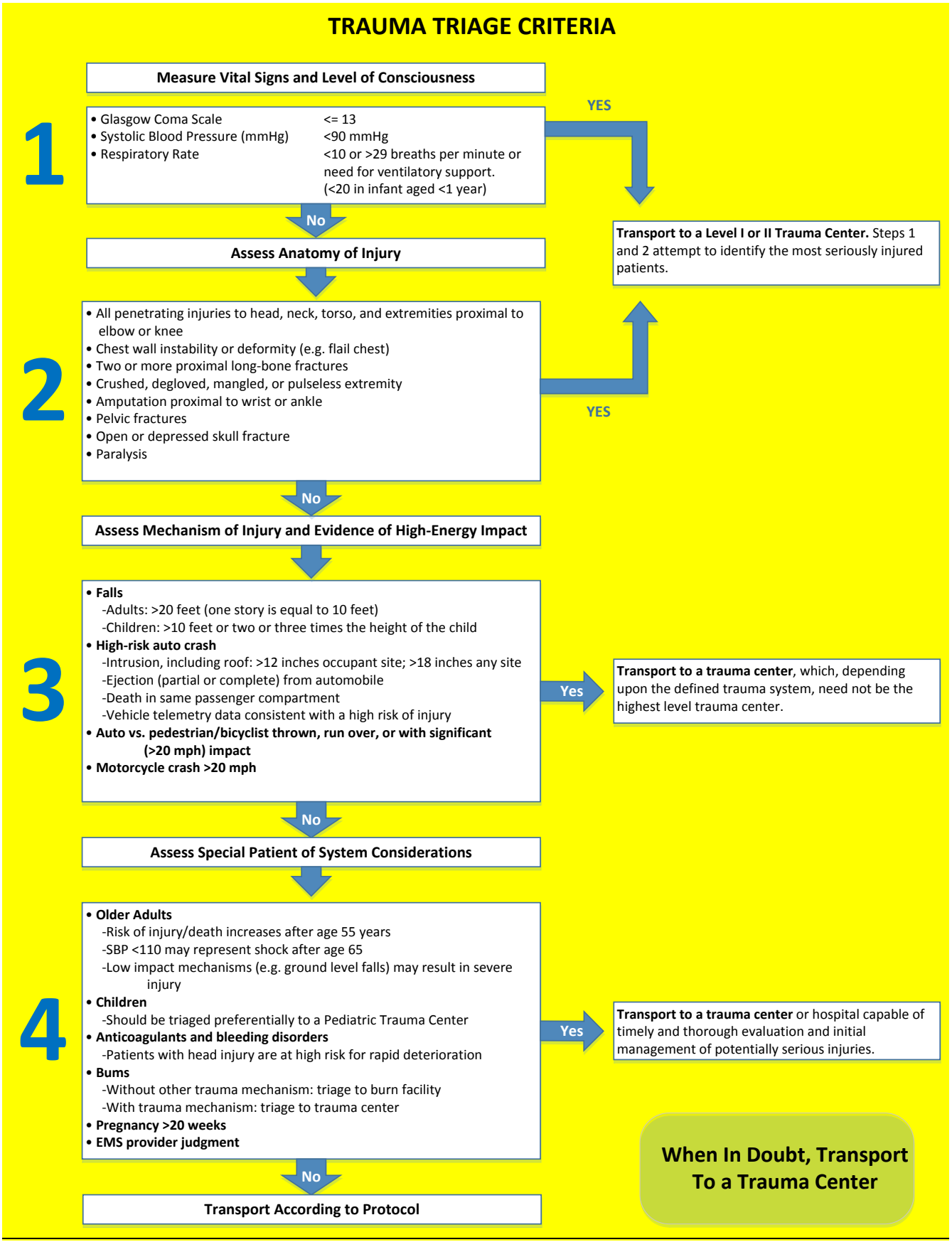
d. Significant electrical injuries with loss of consciousness, voltage in excess of 220, and/or open wounds

e. Electrical injuries resulting in a loss of distal pulses

f. Significant inhalation injury with successful intubation

g. Chemical burns with wounds >5% TBSA

2. All burns with airway compromise, wheezing, stridor, carbonaceous sputum, nasal singeing or significant facial edema must have an evaluation for intubation either by air ambulance personnel or by the emergency physician at the closest appropriate receiving facility prior to transport to the closest Regional Burn Center at UC Davis or Community Regional Medical Center, Fresno, if the ground ambulance is unable to intubate the patient.


TRAUMA TRIAGE CRITERIA
Measure Vital Signs and Level of Consciousness
1
• Glasgow Coma Scale <= 13
• Systolic Blood Pressure (mmHg) <90 mmHg
• Respiratory Rate <10 or >29 breaths per minute or need for ventilatory support. (<20 in infant aged <1 year)
YES
No
Transport to a Level I or II Trauma Center. Steps 1 and 2 attempt to identify the most seriously injured patients.
Assess Anatomy of Injury
2
• All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
• Chest wall instability or deformity (e.g. flail chest)
• Two or more proximal long-bone fractures
• Crushed, degloved, mangled, or pulseless extremity
• Amputation proximal to wrist or ankle
• Pelvic fractures
• Open or depressed skull fracture
• Paralysis
YES
No
Assess Mechanism of Injury and Evidence of High-Energy Impact
3
• Falls
-Adults: >20 feet (one story is equal to 10 feet)
-Children: >10 feet or two or three times the height of the child
• High-risk auto crash
-Intrusion, including roof: >12 inches occupant site; >18 inches any site
-Ejection (partial or complete) from automobile
-Death in same passenger compartment
-Vehicle telemetry data consistent with a high risk of injury
• Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
• Motorcycle crash >20 mph
Yes
Transport to a trauma center, which, depending upon the defined trauma system, need not be the highest level trauma center.
No
Assess Special Patient of System Considerations
4
• Older Adults
-Risk of injury/death increases after age 55 years
-SBP <110 may represent shock after age 65
-Low impact mechanisms (e.g. ground level falls) may result in severe injury
• Children
-Should be triaged preferentially to a Pediatric Trauma Center
• Anticoagulants and bleeding disorders
-Patients with head injury are at high risk for rapid deterioration
• Burns
-Without other trauma mechanism: triage to burn facility
-With trauma mechanism: triage to trauma center
• Pregnancy >20 weeks
• EMS provider judgment
Yes
Transport to a trauma center or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries.
No
Transport According to Protocol
When In Doubt, Transport To a Trauma Center

REPORTING OF SUSPECTED ABUSE

I. AUTHORITY

Health and Safety Code, Division 2.5, Section 1798 and; Child Abuse; California Penal Code, Article 2.5; Elder Abuse: Chapter 1273, Statutes of 1983, SB 1210, Sections 9381(a) and 9382. Welfare and Institutions Code Chapter 11, Part 3, Division 9 and California Welfare and Institutions Code Section 15630.

II. DEFINITIONS

A. "Elder" means any person residing in the state of California who is 65 years of age or older (WIC Section 15610.27)

B. "Dependent Adult" means any person residing in the state of California, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23) Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3)

C. "Reasonable Suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect." (CA Penal Code, 11166)

D. "Mandated Reporters" for **Suspected Child Abuse Cases** are defined under CA Penal Code Section 11165.7. Paragraph 20 of subdivision (a) states, "A firefighter, except for volunteer firefighters" and Paragraph 22 of subdivision (a) states, "Any emergency medical technician I or II, paramedic."

California Welfare and Institutions Code Section 15630 (a) defines "mandated reporter" for **Elder Abuse** as follows; "Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

E. "EMS Personnel" means all EMTs and Paramedics providing care within the Emergency Medical Services System.

F. "Designated Agency" means the agency designated by law to receive a copy of the "Suspected Child Abuse Report." The designated agencies are police or sheriff's department, county welfare or probation department, and district attorney's office.

III. PURPOSE

To describe reporting requirements for EMS personnel when child or elder abuse, sexual assault, or domestic violence is observed or is reasonably suspected.

IV. POLICY

EMS personnel are considered mandatory reporters responsible for reporting incidents of sexual abuse, domestic violence, or suspected abuse to children, dependent adults, or elderly people.

V. PROCEDURE

A. Abuse Reporting (Child, Dependent Adult, and Elder)

1. Suspected Child Abuse Report

   a. Immediately notify the appropriate law enforcement agency. The law enforcement officer assigned will act as a "clearinghouse" for taking the next steps and serves as the initial Child Protective Services contact.

   b. If no law enforcement officer is available, the reporter must follow the following steps AFTER THE APPROPRIATE LAW ENFORCEMENT AGENCY HAS BEEN CONTACTED:

   c. Make phone report to Child Protective Services Agency
      1) Stanislaus County – (209) 558-3665
      2) Calaveras County – (209) 754-6452, after hours (209) 754-6500
      3) Amador County – (209) 223-6550, after hours (209) 223-1075
      4) Alpine County – (530) 694-2235 then 1, after hours (866) 900-0525
      5) Mariposa County – (209) 966-7000

   d. Written Report must be followed within twenty-four (36) hours. The written report and instructions on "Suspected Child Abuse Report" is attached. **See attachment 1**.

2. Suspected Dependent Adult/Elder Abuse Report

   a. If the alleged abuse has occurred in a **long-term care facility**:
      1) Call Ombudsman Services of Northern California:
         i. 1-800-896-4042
            TTY 1-800-896-2512

   b. If the alleged abuse has occurred anywhere else:

      1) Call Adult Protective Services
         i. Stanislaus County – (800) 336-4316
         ii. Calaveras County - (209) 754-6452, after hours (209) 754-6500
         iii. Amador County - (209) 223-6550, after hours (209) 223-1075
         iv. Alpine County - (530) 694-2235 then 1, after hours (866) 900-0525
         v. Mariposa County - (209) 966-7000

      2) Written report must be followed within twenty-four (48) hours. The written report and instructions on "Report of Suspected Elder Abuse" is attached. **See attachment 2.**

3. The identity of all persons reported under this article shall be confidential.

B. Sexual Assault

1. Sexual assault shall be reported in situations involving elder, dependent adult, child, or domestic violence.

2. Transport patients who have been sexually assaulted to nearest hospital or hospital of choice for evaluation and evidentiary exam.

3. Discourage any activity that would compromise evidence collection prior to transport such as bathing, brushing teeth, brushing hair, urinating, defecating or changing clothes.

4. Document essential elements:

    a. Name of person making report
    b. Name of victim
    c. Present location of victim
    d. Nature and extent of injury
    e. Information that led reporting person to suspect sexual assault
    f. Other information as requested.

C. Domestic Violence

1. Suspicion is to be reported immediately to the appropriate law enforcement agency.

2. The identity of all persons reported shall be confidential

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Attachment 1

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

OSP 03 74570

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME:_____

PLEASE PRINT OR TYPE

CASE NUMBER:_____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services) AGENCY

ADDRESS Street City Zip DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED – TITLE TELEPHONE ( )

C. VICTIM One Report Per Victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL		CLASS	GRADE
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME	
IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT	PHOTO'S TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK	

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02) ***DEFINITIONS AND INSTRUCTIONS ON REVERSE***

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY-District Attorney's Office; YELLOW COPY-Reporting Party

Attachment 2

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER ☐ M ☐ F	ETHNICITY	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
		( )	☐ M ☐ F							

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE	(STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)	TELEPHONE
					( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)
☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL
☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
☐ ASSAULT/BATTERY
☐ CONSTRAINT OR DEPRIVATION
☐ SEXUAL ASSAULT
☐ CHEMICAL RESTRAINT
☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION

f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated; e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME IF CONTACT PERSON ONLY ✓ CHECK ☐	*RELATIONSHIP

*ADDRESS	*CITY	*ZIP CODE	*TELEPHONE
			( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE	DATE/TIME
	( )	

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

SOC 341 (12/06)

POLICY: 560.11
TITLE: **Documentation of Patient Contact**
EFFECTIVE: 2/1/2025
SUPERSEDES: 6/10/2020
REVIEW: 2/2027

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

DOCUMENTATION OF PATIENT CONTACT

I. **AUTHORITY**: California H & S Code, Division 2.5; CCR, Title 22, Division 9.

II. **PURPOSE**: To identify required patient information, assessment findings, prehospital treatments, and responses to treatments, and to establish a mechanism for gathering, recording, and reporting this information.

III. **DEFINITIONS**:

Competent Person / Patient means an individual who is age eighteen (18) years or older, or an emancipated minor, with a capacity to understand the nature of their medical condition, if one exists, and is not impaired by alcohol, drugs / medications, mental illness, traumatic injury, grave disability, or dementia.

EHR means electronic health record. An EMS ePCR is an electronic health record.

ePCR means electronic prehospital care report. ePCR platforms include Zoll emsCHARTS, ESO, Image*Trend*, and others. ePCR platforms must comply with current local, State, and Federal documentation requirements (e.g., NEMSIS, CEMSIS, etc.).

Health Agent means any person other than law enforcement officer or coroner who has authority or responsibility for the disposition of a body. A health agent could be a private physician, home health nurse, or public health nurse.

Patient means any individual encountered by EMS personnel who, upon

questioning, requests assessment, treatment, or transport or who appears to exhibit evidence of acute illness or injury.

Patient Contact means anytime during an EMS call, a person is identified as a patient as defined in this policy.

Person means any competent individual encountered by EMS personnel who upon questioning, denies illness or injury and does not exhibit any evidence of illness or injury. The individual did not call 911 or direct 911 to be called for medical complaint.

Prehospital Care Report or **PCR** means the form, electronic or paper, used to document prehospital medical care information according to the current standards established by the Mountain Counties Emergency Medical Services Agency.

Triage Tag refers to the patient documentation tag currently in use within the Mountain Counties EMS system for the prioritization of patients of a disaster or multi-casualty incident.

IV. **POLICY**:

a. First Responder agencies arriving at the scene of an EMS call shall document all available details of the incident on an EMS First Responder Report. The original copy of the form shall be given to the transporting ambulance crew to be scanned into the ePCR and delivered with the patient to the destination hospital for inclusion in the patient's medical records.

b. An ePCR shall be completed for every response within the MCEMSA jurisdiction by a contracted EMS provider. If a response is reassigned to a different EMS unit, the originally dispatched EMS unit that was cancelled from the call does not need to complete a PCR to comply with MCEMSA policy.

c. The ePCR is to be completed by the individual primarily caring for the patient. Responsibility for ensuring that patient documentation is complete and accurate rests with the highest certified or licensed prehospital care provider, paramedic preceptor, or field training officer attending the call.

d. An ePCR or triage tag (when appropriate) shall be completed for every patient contact.

e. In cases of prehospital death, a completed triage tag or PCR shall be

left with the County Coroner, Law Enforcement, or Health Agent with jurisdiction over the scene by the ambulance personnel prior to departing the scene. County Coroner may provide a mechanism for providers to electronically submit the ePCR.

f. For patients transported to a hospital, the original completed ePCR shall be delivered to appropriate hospital staff upon completion of the call and before leaving the receiving facility. If unable to complete an ePCR due to technical challenges or system demands, a paper Documentation of Patient Contact (DPC) must be left at the receiving facility with appropriate staff. The ambulance service provider is responsible for returning the original completed ePCR as soon as possible and no later than within 12 hours of the time the ambulance crew departed from the hospital or prior to the crew going off duty, whichever occurs first. If any PCR is not delivered to the receiving facility within 12 hours, an Unusual Occurrence Report shall be submitted to the EMS Agency within 24 hours.

V. **PROCEDURE**: Each ePCR platform will require specific training for its effective use. Every PCR, whether hand-written or electronic, must contain at a minimum the following information when such information is available:

a. The date and estimated time of incident.

b. The time of receipt of the call.

c. The time of dispatch to the scene.

d. The time of arrival at the scene.

e. The time of patient contact.

f. The location of the incident.

g. The patient's:

- Name
- Age or date of birth
- Gender
- Weight
- Address
- Chief complaint
- Vital signs as defined in MCEMSA Policy 554.01 Patient Assessment.

h. Appropriate physical assessment.

i. Primary Provider Impression.

j. The emergency care rendered and the patient's response to such treatment.

k. Patient disposition.

l. The time of departure from the scene.

m. The time of arrival at receiving facility (if transported).

n. Time patient care was transferred to receiving facility (if transported).

o. The name of the receiving facility (if transported).

p. The name(s) and unique identifier number(s) of the paramedic(s) and EMT(s).

q. Signature(s) of the paramedic(s) and EMT(s). Prehospital provider signatures should be consistent with their government-issued identification (e.g., passport or driver license).

MOUNTAIN COUNTIES EMS FIRST RESPONDER REPORT

Call Date ____/____/____	Department	Unit Number	Incident Name / Number	Medical Aid Number

Response Code ☐ Code 2 ☐ Code 3	Time of Call	Time Enroute	Time @ Scene	Patient Contact	Nature of Illness / Mechanism of Injury

Patient Name (Last, First, Middle)	Patient Address	Incident Location

Patient Age	Patient DOB ____/____/____	Patient Gender	Estimated Patient Wt.	Number of Patients at Scene

Chief Complaint_____ Allergies_____

START Triage Category (R.P.M.) BLACK ☐ RED ☐ YELLOW ☐ GREEN ☐

History of Present Illness / Injury _____ Medications_____

Initial Physical Examination (check box for unremarkable exam findings)

- Head ☐ _____
- Neck ☐ _____
- Chest ☐ _____
- Abdomen ☐ _____
- Back ☐ _____
- Pelvis ☐ _____
- Limbs ☐ _____
- Neuro ☐ _____
- Skin Signs ☐ _____

Glasgow Coma Scale (GCS)

Eye	Verbal	Motor
4 Spontaneous	5 Oriented	6 Obeys
3 Voice	4 Confused	5 Localizes
2 Pain	3 Inappropriate	4 Withdrawal
1 None	2 Incomprehensible	3 Flexion
	1 None	2 Extension
		1 None

TIME	E	+	V	+	M	=	Total
_____	__	+	__	+	___	=	_____
_____	__	+	__	+	___	=	_____

Care Giver	Time	Procedure	Response / Comments	Temp.	B / P	Pulse Rate	Resp. Rate	Pulse Oxy.	Blood Sugar	Pain (0-10)
					/					
					/					
					/					
					/					
					/					
					/					
					/					

☐ **REFUSAL OF SERVICE**

I HEREBY RELEASE _____ OF ANY LIABILITY WHICH MAY BE INCURRED DUE TO ANY REFUSAL OF THEIR SERVICES. I HAVE BEEN ADVISED TO SEE A PHYSICIAN OF MY CHOICE.

X _____ Time: _____

(Hospital Use Only)

PATIENT LABEL

Special Scene Conditions
- ☐ Fire
- ☐ Complicated extrication
- ☐ DNR
- ☐ Drug use suspected
- ☐ Alcohol use suspected
- ☐ Haz-Mat
- ☐ MCI
- ☐ Multiple EMS providers
- ☐ Provider exposure
- ☐ Unsafe scene
- ☐ Other - Abuse/neglect report _____

Safety Equipment
- ☐ Lap restraint
- ☐ Lap/shoulder belt
- ☐ Child safety seat
- ☐ Airbag
- ☐ Helmet
- ☐ Protective clothing

MVA Conditions
- ☐ Bent steering wheel
- ☐ Death in same vehicle
- ☐ Ejection
- ☐ Passenger compartment intrusion
- ☐ Rollover

Insurance Info. (Carrier, Member ID, etc.)

Additional Personnel on Scene:

Care Transferred To:

Name: _____ Time: _____

Report Prepared By:

Name: _____ Signature: _____

Distribution: Original – with patient to Emergency Department Duplicate – department records rev. 11/2023

Mountain Counties
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 560.12
TITLE: PCR Instruction Book

EFFECTIVE: August 15, 2025
REVIEW: August 2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Patient Care Record Instruction Booklet

Mountain Counties
Emergency Medical Services Agency

August 2025

GENERAL INSTRUCTIONS

- Patient Care Reports shall be completed for all patient contacts as defined in Policy No. 560.11, Documentation of Patient Contact.

- **Be sure to attach each patient's ECG strips to the receiving hospital's copy of the Patient Care Report.**

- A separate form must be completed for each patient of each response for care (e.g. a patient transported to a hospital who is then transferred to another facility requires two PCRs).

- If a patient refuses care, be sure to note that fact in the **Procedure/Medication** section, and complete and obtain the patient's signature on a Refusal of Service form.

- **Taber's Cyclopedic Medical Dictionary** has been adopted by the agency to govern the spelling, definition and abbreviation of all medical terms and words for patient care charting, except as otherwise specified in policy or in this instruction booklet. The use of medical abbreviations not listed in Taber's, policy or this instruction booklet should be avoided.

- **All times are to be recorded on the PCR in 24 hour format (e.g. 23:14).**

- The patient care report is to be completed by the individual primarily caring for the patient. However, the responsibility for ensuring that patient documentation is complete and accurate rests with the highest certified or licensed prehospital care giver or field training officer attending the call.

SPECIFIC INSTRUCTIONS

The following is a brief explanation of each item of information that should be completed on each form.

The bolded titles correlate to the section titles on the PCR. A sample PCR has been included in this booklet for reference.

Call Date	Indicate the month, day and year the call is received by the provider's dispatch center (e.g. 03/28/93).
Provider Number	Enter the ambulance provider company identification number.
Unit Number	Enter the ambulance unit identification number.
Incident Number	Enter the incident number assigned by the dispatch center.
Inter-facility Transfer	When performing an inter-facility transfer, enter the number of the

Number	Inter-facility Transfer Form in this space. "Inter-facility transfer" refers to pre-arranged transfers between acute care facilities. Transports from doctor's offices or nursing homes to emergency departments are to be considered emergency calls rather than transfers, and do not require transfer numbers.
Call Disposition	Enter the appropriate Call Disposition code to indicate the final result of the EMS call
Response and Transport Codes	Check level of code enroute to scene, and level of code enroute to final destination. Code 1: Pre-scheduled non-urgent response Code 2: Urgent response, no red lights or siren Code 3: Emergent response, red lights and siren
Time of Call	Enter the time the call is received by the provider's dispatch center.
Time Enroute	Enter the time the EMS unit responding to the call begins physical motion (wheels rolling for EMS ground unit, lift-off for EMS aircraft).
Time First ALS on Scene	Enter the time the first ALS unit arrived on scene, when different than the transporting unit.
Time Arrived on Scene	Enter the time the EMS unit arrives within 200 feet of the location it was dispatched to.
Time Left Scene/Call Canceled	Enter the time the EMS unit leaves the location it was dispatched to, or the time the call is canceled, as appropriate.
Time Arrived at Destination	Enter the time the EMS unit stops at its final destination.
Contact Made with:	Check Base Hospital only when a Base Hospital was contacted for orders or direction. Check Receiving Hospital when Hospital Contact was made (regardless of Base or non-Base Hospital status) without request for orders or direction. Check Disaster Control Facility when the DCF was contacted. Check None when contact was not possible or not made from the field.
Time of Contact	If contact is made with a base hospital, receiving hospital or DCF, enter the time of first contact.

Patient Name	Enter the patient's last name, first name, middle initial (e.g. Smith, John Q.)
Patient Address	Enter the patient's home address including number, street, city or town, and zip code.
Incident Location	Enter the actual location of the scene including either an address, landmark or intersection as well as specific location of the patient, including city or town. If performing an inter-facility transfer, note the name of the hospital and department the patient is taken from.
Patient Age	Enter the patient's age, or estimated age if the actual age is unknown, in month or years, as appropriate.
Patient DOB	Enter the patient's date of birth or estimated date of birth if actual age is unknown for electronic documentation (example: 01/01/YYYY).
Patient Gender	Choose the appropriate option.
Estimated Patient Weight	Enter patient's estimated weight, in kilograms.
County	Enter the county where the scene is located (or two-digit county code -refer to the County codes list at the back of this booklet).
Map Zone	Enter the map zone number assigned to the section of the county in which the scene is located. Each provider should provide either a zone map or the zone number through their dispatch center.
Number of Patients at Scene	Enter the number of persons requiring medical care at the scene.
Chief Complaint	Describe the patient's impression of the primary reason / major symptoms responsible for the ambulance call. (A patient with major extremity injuries may have a chief complaint of back pain, and if he has not noticed his extremity injuries, these injuries might not be a part of the chief complaint). Examples of chief complaints: shortness of breath, pain right leg, headache, chest pain, fainting. Pain assessment should include "Patient denies pain" or "patient c/o midsternal chest pain, 4/10". If the patient is unconscious or has no complaint, enter "NONE."
Medical History	Document a summary of the patient's current medical problem, and any other information that pertains to the problem that is not a part of the physical examination. Include here such information as what brought on symptoms, and what symptoms were experienced.

Include descriptions of events surrounding the incident, past medical history which relates to the present illness, major unrelated medical problems, recent use of medications, and observations by bystanders. If information is received by someone other than the patient, include who gave the information.

Information obtained by observing or examining the patient belongs under in the Initial Physical Examination section, not the Medical History section.

Allergies — Enter anything to which the patient has a known allergy. If the patient has no known allergies, record "NKA" (no known allergies).

Medications — Enter any prescription or non-prescription medication taken regularly by the patient. If none, record "none."

Initial Physical Examination — Document all of the pertinent positive and negative physical exam findings, including those discovered during secondary assessment.

Prehospital care personnel may use the "unremarkable" check boxes located in the Physical Exam section of the Patient Care Record when recording "unremarkable" physical exam findings as defined below:

Documentation of initial pain assessment for every patient should be included here, utilizing a standard severity scale (1 - 10, 10 being the worst pain ever, and 1 being minimal pain).

Head: No obvious trauma, deformity or depression. Absence of fluid or blood in ear and nasal passages. Pupils equal and reactive to light. No tenderness to face or head. Jaw moves freely. Normal oral hydration. No abnormal odor to breath.

Neck: No obvious trauma, deformity, discoloration, or scars. No tenderness upon palpation. Veins non-distended. Carotid pulses present. Trachea mid-line. Absence of stoma.

Chest: Equal bilateral expansion of anterior chest with each respiratory effort. Bilateral upper and lower lobes clear on auscultation. No obvious trauma or scars.

No crepitus or tenderness upon palpation.

Abdomen: No obvious trauma or scars. No tenderness guarding, masses, or rigidity in all four quadrants

following palpation. No pulsatile masses.

Back: No obvious trauma or scars. No deformity or tenderness upon palpation.

Pelvis: No obvious trauma or deformity. No pain upon compression of the iliac crests bilaterally or the symphysis pubis anteriorly. No genital or perineal trauma. No urethral blood.

Limbs: No obvious trauma, swelling, deformity or tenderness. Full range of motion. Distal pulses intact.

Neurologic: Glasgow Coma Score of 15. Appropriate sensation in all extremities. Normal muscle tone. Equal grip strength and dorsi/plantar flexion. Sensation intact and equal in all extremities.

Skin Signs: Normal temperature, moisture and color. Mucus membranes pink. Capillary refill of 2 seconds or less.

Changes in physical exam findings following treatment or during transport, such as return of pulses in an injured extremity following traction and splinting, should be documented in the Procedure/Medication and Response section.

GCS

For each Glasgow Coma Scale (GCS) assessment, enter the time, GCS sub-scores and GCS total in this section. Pediatric GCS equivalences are listed in the Patient Report Form Codes key at the back of this booklet.

Mechanism of Injury

Complete this section only for patients who have sustained injury, including falls, burns, electric shocks, etc., from the Mechanism of Injury codes list.

Types of Illness/Injury

Enter the patient's most significant types of illness/injury codes.

Field Clinical Impression

Describe your clinical impression or working diagnosis of the patient's illnesses or injuries on this line. An example of a field clinical impression would be "2° burns over 30% of body."

Care Giver

For others who provided care to the patient prior to you taking over care, enter agency abbreviation (such as "FD" or "PD"), or "BS" for

	bystander, or "PH" for physician on scene. For ambulance personnel, enter certification number, or A, B, or C from signature lines at the bottom of the form.
Time	Enter the time each procedure, medication, or assessment is administered, in 24 hour time.
Procedure/Medication Code and Description	Enter the description of each procedure or medication administered, as well as the code for that procedure or medication from the code lists. For medications also include dosage and route.
Response/Comments/ ECG/MD Signature: Base Order	**Enter any response or comments related to the procedure, medication, or assessment, including ECG interpretation if applicable. MD Signature is required for ALL Base Hospital Orders. (Be sure to also attach the patient's ECG strips to the receiving hospital's copy of the PCR when applicable.)**
Respiration Rate	Enter respiration rate. Note respiration sounds in the Response/Comments section.
Blood Pressure	Enter blood pressure.
Pulse Rate	Enter pulse rate. Note quality of pulse in the Response/Comments section.
Pain Level	Document level of pain on every patient, utilizing a standard severity scale (0 - 10). Additionally, document level of pain following any interventions for pain, and as part of periodic condition updates in every patient who presented with pain as part of the chief complaint.

NOTE: Usually, not all fields in this section will be filled in for a given row. For instance, when taking vitals, the **Procedure/Medication** field can be left blank. Similarly, if a procedure or medication is administered and no vitals are taken immediately, the vitals fields should be blank for that row.

Vital signs should be assessed and documented as part of the initial assessment on every patient, and re-evaluated following any procedure or treatment that could have an effect on the VS. In addition, periodic VS updates should be documented according to patient condition (every 5 minutes for unstable patients, and every 15-20 minutes on stable patients).

As much as possible, information in this section should be recorded in chronological order.

An example completed PCR for a burn patient is included at the back of this booklet.

Medication Wasted	Document medication name, amount, and time of wasted medication. Signatures must be obtained from the wasting party and witness.	
Special Scene Conditions	Document conditions relating to the circumstances at the scene.	
	ALS without base hospital contact	ALS procedures or medications listed in the Treatment Guidelines below "Contact Base Hospital" were performed prior to, or without, base hospital contact. If this box is checked, the completion of an ALS Without Base Hospital Contact form (560.20) is also required.
	Complicated extrication	Patient care has been affected by a difficult extrication of the patient.
	DNR	Patient has a valid Do Not Resuscitate medallion or form.
	Drug use suspected	Illicit drug use is suspected. Drug use suspicion includes medic suspicion, patient self-reported use, and police reported suspicion.
	ETOH use suspected	ETOH use is suspected. ETOH use suspicion includes medic suspicion, patient self-reported use, and police reported suspicion.
	Hazardous material	Hazardous material precautions or procedures were utilized, or when a hazardous material was present or involved at the scene of a call.
	MCI	A scene has been declared as an Multi-Casualty Incident according to regional policy.

Multiple EMS providers	More than one ALS ambulance is present at the scene of a call.
Possible provider exposure	EMS personnel may have been exposed to pathogens at the scene of a call.
Unsafe scene	Any call where patient care may have been affected because the scene of that call was in some way unsafe.
Other	Briefly describe any additional special scene condition that may have affected patient care on a call.

Safety Equipment Used Document safety equipment used by the patient.

MVA Conditions Document conditions of the vehicle and/or passengers.

Destination Decision Reason Document reason which most closely describes the reason for taking this patient to his/her particular destination.

Tier I Trauma Document all factors which exists for Tier I Trauma patients.

Tier II Trauma **Document all factors which exists for Tier II Trauma patients.**

Pediatric Trauma **Document all factors which exists for Pediatric Trauma patients.**

Receiving Hospital Enter the facility receiving the patient (or facility code from the Hospital codes list).

Base Hospital Enter the facility providing medical control (or code from the Hospital codes list).

NOTE: The current hospital codes are two digits long. However, four spaces have been allowed on the PCR in case state-assigned four-digit hospital identifiers are used in the future.

Base MD, MICN Enter the names of the base physician and MICN.

Care Transferred To Enter the name of the agency and of the individual that accepts care of the patient. Also record the time care is transferred here.

Certification Number, Name, Signature On the first line, enter the certification number, name and signature of the person who primarily attended the patient. On subsequent lines, enter the certification numbers, names and signatures of other team members.

Continuation form used	Check this box if a Patient Care Report Continuation form is used. If a continuation form is used, be sure to record the corresponding PCR Number on the continuation form. Also, be sure to sign the continuation form at the end of the text entered there.

POLICY: 570.20
TITLE: Determination of Death in the Prehospital Setting

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

DETERMINATION OF DEATH IN THE PREHOSPITAL SETTING

I. AUTHORITY

California Health and Safety Code, Division 2.5, sections 1797.220, 1798, and 102850; and California Code of Regulations, Title 22, Division 9, sections 100107.

II DEFINITIONS

A. **Obviously Dead** means a person who has one or more of the following:

1. Decapitation
2. Massive crushing and/or penetrating injury with evisceration of the heart, lung or brain.
3. Incineration
4. Decomposition of body tissue
5. Rigor mortis
6. Post-mortem lividity
7. Blunt traumatic arrest
8. Declared MCI where triage principles and available resources preclude initiation of resuscitation

III PURPOSE

To establish standards for authorized prehospital emergency medical care personnel to follow in determining death of a patient in the pre-hospital setting.

IV. POLICY

Pre-hospital emergency medical care personnel shall not initiate nor perform CPR, basic life support, or advanced life support on patients determined to be obviously dead as defined in this policy.

V. PROCEDURE

A. When the initial patient assessment reveals **Obvious Death**:

1. A Patient Care Report (PCR) shall be completed. All appropriate patient information must be included in the PCR and shall describe the patient assessment and the time the patient was determined to be obviously dead.

2. Base Hospital contact is not required for patients determined to be obviously dead.

B. For patients who do not meet the Obviously Dead definition, appropriate treatment measures shall be initiated.

1. Termination of resuscitation (TOR) may be declared without base hospital contact if all of the following criteria are met per appropriate type of cardiac arrest:

   a. Adult Cardiac Arrest, Non-Traumatic (554.11)
      i. EMS did not witness Cardiac Arrest and
      ii. There was no shockable rhythm and
      iii. No Return of Spontaneous Circulation (ROSC) after 20 minutes of BLS and/or ALS resuscitation and
      iv. NOT hypothermic and
      v. NOT a victim of submersion and
      vi. NOT obviously pregnant and
      vii. Reversible causes treated.

   b. Adult Traumatic Arrest (554.83)
      i. NOT hypothermic and
      ii. NOT a victim of submersion and
      iii. NOT obviously pregnant
      iv. Reversible causes treated
      v. No ROSC after 5 two-minute cycles of High Performance CPR.

   c. Pediatric Cardiac Arrest, Non-Traumatic (555.11)
      i. NOT hypothermic and
      ii. NOT a victim of submersion and
      iii. NOT obviously pregnant and
      iv. Reversible causes identified/treated and
      v. After 15 two-minute cycles of High-Performance CPR performed **AND** **minimum** one dose of Epinephrine,
      vi. NO ROSC **AND**
      viii. Asystole on the monitor.

   d. Pediatric Traumatic Arrest (555.83)
      i. NOT hypothermic and
      ii. NOT a victim of submersion and
      iii. NOT obviously pregnant and
      iv. Reversible causes identified and treated and
      v. NO ROSC after 5 two-minute cycles of High-Performance CPR performed.

2. If TOR criteria have not been met, an order to terminate resuscitation may be given by the Base Hospital Physician. A Patient Care Report shall be completed to include all appropriate patient information, all interventions, and the criteria outlining discontinuation of resuscitative efforts with the time that the Base Physician determined the patient to be dead.

C. Pre-hospital emergency medical care personnel shall notify the appropriate law enforcement agency when a patient has been determined to be dead and shall remain on scene until released by the law enforcement agency. The body and the patient

documentation may be left in the care of an authorized first responder agency if another patient requires transport or the ambulance has been requested by an authorized ambulance dispatch center to respond to another emergency.

D. In accordance with agency documentation policy (560.11), the original PCR or Triage Tag shall remain with the body for inclusion in the law enforcement agency's report.

E. If a determination of death is made while transporting a patient from a scene call, transport of the body should continue to the original receiving facility destination and transport mode downgraded to Code 2.

F. Policies and procedures relating to medical operations during declared disaster situations or multiple casualty incidents will supersede this policy. (See Policies 810.00, 812.00, and 820.00 for disaster policies)

G. Crime Scene Responsibility, including presumed accidental deaths and suspected suicides:

1. Authority for crime scene management shall be vested in law enforcement. To access the patient(s), it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

2. If law enforcement is not on scene, EMS personnel shall make every effort to preserve the integrity of the scene by minimizing access of unnecessary personnel to the scene until law enforcement arrives.

POLICY: 570.21
TITLE: Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

EFFECTIVE: 07/01/2017
REVIEW: 07/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

I. AUTHORITY

California Health and Safety Code, Division 1, Part 1.8, Section 442-443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

II. DEFINITIONS

A. **Advance Health Care Directive (AHCD)**: A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney.

B. **Aid-in-Dying Drug**: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

C. **Basic Life Support (BLS) Measures:** The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted Ventilation via a bag-valve-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED)

D. **Comfort Measures:** Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

E. **Do Not Resuscitate (DNR):** DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- No chest compressions
- No defibrillation
- No endotracheal intubation
- No assisted ventilation

F. **End of Life Option Act:** California State law authorizes an adult, eighteen (18) years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

G. **Ombudsman:** The Office of the Ombudsman works independently as an intermediary to provide individuals with a confidential avenue to address complaints and resolve issues at the lowest possible level. The Office proposes policy and procedural changes when systemic issues are identified.

H. **Patient Advocate:** Patient advocacy is an area of lay specialization in health care concerned with advocacy for patients, survivors, and care takers. The patient advocate may be an individual or an organization, often, though not always, concerned with one specific group of disorders.

I. **Physician Orders for Life Sustaining Treatment (POLST):** A signed, designated physician order form that addresses a patient's wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

J. **Prehospital Emergency Medical Services (EMS) Personnel:** Persons who have been certified as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.

K. **Resuscitation: Intervention**(s) intended to restore cardiac activity and respirations, for example:

- Cardiopulmonary resuscitation (CPR)
- Defibrillation
- Drug therapy
- Other life saving measures

L. **Standardized Patient-Designated Directives:** Forms or medallion(s) that recognizes and accommodates patient's wish to limit prehospital treatment at home or the scene of an incident, in healthcare facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Attachment 1)
- Physician Orders for Life-Sustaining Treatment (POLST) (Attachment 2)
- State EMS Authority-Approved DNR Medallion (V.C.2.b)

M. **Supportive Measures:** Medical intervention(s) used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhagic control
- Oral hydration
- Glucose administration
- Pain control

N. **Valid DNR Order for Patients in a Licensed Health Care Facility:**

- A written document in the medical record with the patient's name and this statement "Do Not Resuscitate", "No Code", or "No CPR" that is signed and dated by a physician; or

- A verbal order to withhold resuscitation given by the patient's physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient's medical record; or
- POLST with DNR checked; or
- AHCD when the instructions state resuscitation should be withheld/discontinued.

O. **Valid DNR Order for Patients at a Location Other Than a Licensed Facility:**

- Fully executed California Emergency Medical Services Authority and the California Medical Association approved DNR form signed and dated by the patient's physician; or
- A Medic Alert bracelet inscribed "Do Not Resuscitate EMS"; or
- A Physician Orders for Life-Sustaining Treatment (POLST) form; or
- A written, signed order in the patient's medical record.

III. PURPOSE

To establish criteria for prehospital EMS personnel when they encounter patients with Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives.

IV. PRINCIPLES

A. The right of patients to refuse unwanted medical intervention is supported by California Statute.

B. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.

C. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.

D. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.

E. Photocopies of all the patient-designated directives are acceptable.

F. A conscious patient who is oriented to person, place, time and purpose may revoke their patient-designated directive at any time.

V. POLICY

A. General Procedures for EMS Personnel:

1. Confirm the patient is the person named in the patient-designated directive

2. Initiate BLS measures immediately on patient in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing measures outlined in Determination of Death in the Prehospital Setting Policy 570.20

3. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive

4. If the patient's condition deteriorates during transport, including Emergency 9-1-1 and Non-Emergency Inter-Facility Transfers (IFTs), and the patient has a valid DNR, transport the patient to the facility requested/designated by the physician or family member(s). If no facility is requested or designated then transport to the closest facility.

B. Documentation of a DNR incident shall include, but is not limited to, the following:

1. Check the "DNR" box on the electronic Patient Care Report (ePCR);

2. Describe the care given. Document the base hospital physician's name, if consulted, and the date of the DNR directive;

3. Note the removal of any invasive equipment;

4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the ePCR;

5. When possible, provide a copy of the AHCD and/or other patient-designated directive with the ePCR.

C. Directive-Specific Procedures

1. AHCD

a. A valid AHCD must be:

i. Completed by a competent person age 18 or older
ii. Signed, dated, and include the patient's name
iii. Signed by two witnesses or a notary public
iv. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility

b. If the situation allows, prehospital EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.

c. Base hospital contact is required for any AHCD instructions other than withholding resuscitation.

2. State EMS Authority approved DNR medallion(s)

a. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility

b. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are two (2) medallion providers approved in California:

i. Medic Alert Foundation

ii. Caring Advocates

c. If the medallion is engraved "DNR," treat in accordance with this policy

d. If the medallion is engraved "DNR/POLST" and the POLST is available, treat as indicated on the POLST.

e. If the medallion is engraved "DNR/POLST" and the POLST is **NOT AVAILABLE**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

a. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signature is necessary.

b. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.

c. Prehospital EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.

d. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

e. Contact the base hospital for direction in the event of any unusual circumstance.

4. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered and aid-in-dying drug:

a. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner (Exhibit B)." However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

b. There are no standardized "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation. If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:

   i. The document is identified as a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner."
   ii. Patient's name, signature and dated

c. Provide comfort measures (airway positioning, suctioning) and/or BLS airway/ventilation measures

d. Withhold resuscitative measures if patient is in cardiopulmonary arrest.

e. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to consult with their base hospital whenever possible.

f. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.

g. Obtain a copy of the final attestation and attach it with the EMS ePCR when possible.

Cross Reference Policies:
Policy 560.11 Documentation of Patient Contact
Policy 570.20 Determination of Death in Prehospital Setting
Policy 570.35 Refusal of EMS Service

Exhibit A
Physician Orders for Life-Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Exhibit B
Example of Final Attestation Form

FINAL ATTESTATION FORM

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, I _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potentially associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

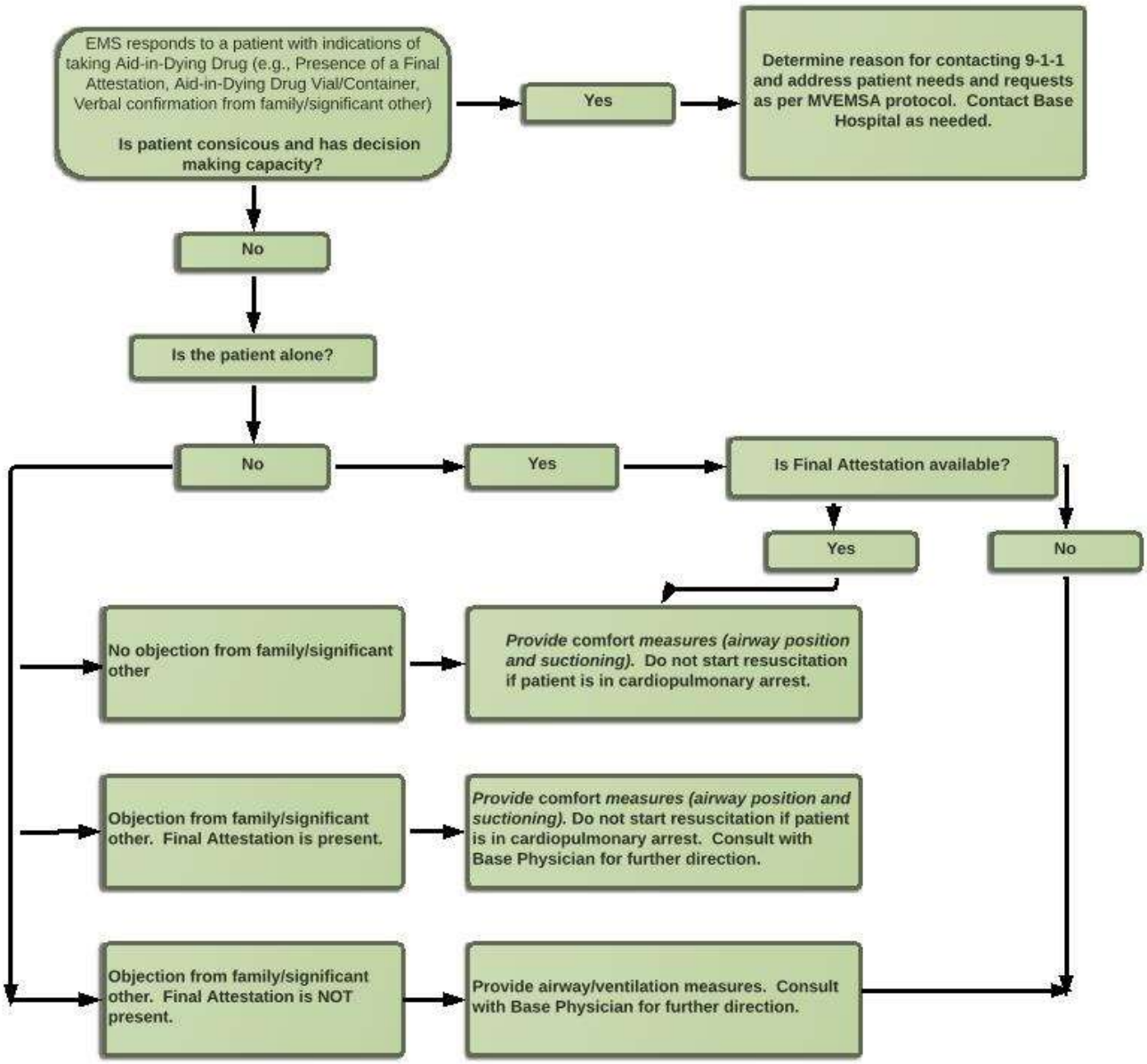
_____ I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: _____
Dated: _____
Time: _____

Exhibit C
End of Life Option Algorithm



APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 4/13/2005
SUPERSEDES:
REVISED: 03/2005
REVIEW DATE: 04/2010

PHYSICIAN ON SCENE

I. AUTHORITY

Health and Safety Code, Section 1797.220, and Title 22, California Code of Regulations, Section 100169.

II. PURPOSE

To provide direction for prehospital personnel when a physician is present on the scene of an EMS call.

III. POLICY

Prehospital ALS personnel shall accept direction from a physician at the scene of an EMS call only under the circumstances described below.

IV. PROCEDURE

A. If a physician wishes to direct the ALS care of a patient in the field and they are not recognized as a physician by EMS personnel, identification shall be requested. Identification should include a valid California Medical License and some form of identification that includes a picture (e.g. drivers license, hospital I.D.). Identification will not be required for calls originating at a physician's office, hospital or clinic.

B. For calls originating at a private physician's office, clinic, emergency department, or when a patient's own private physician is on-scene, ALS personnel may follow the attending physician's written direction and will not be required to make base hospital contact unless: 1) the physician's orders do not comply with Regionally approved policies or treatment guidelines, or 2) the physician's orders do not comply with Regionally approved ALS/BLS scope of practice, or 3) there is an unexpected development in route which would require base hospital contact. Any written directions given by the physician shall accompany the patient and a copy shall be attached to the Patient Care Record.

C. For calls originating at the scene of a medical emergency in which a physician is present who is not the patients private physician, or if the attending physician's orders described in paragraph B, do not comply with approved treatment guidelines or scope of practice, the physician shall either be 1) advised that prehospital personnel function under the direction of a base hospital physician and place them in contact with the base physician; or 2) presented with a "Note to Physician on Involvement with EMT IIs and EMT-P (Paramedic)" card endorsed by the California Medical Association and the State EMS Authority (see page 3 of 3); or 3) informed that he/she may assume medical direction if they are also willing to accompany the patient in the ambulance to the receiving hospital.

D. If the physician is not willing to accompany the patient and still wishes to direct the care, EMS personnel shall establish radio or telephone contact with the appropriate base hospital and explain the situation to the base hospital physician.

E. If the base hospital physician so directs, the ALS personnel may take medical direction from the private physician as long as that direction is consistent with their scope of practice. In this situation, the base hospital physician shall assume medical control upon the initiation of transport.

F. ALS personnel accepting appropriate direction from a private physician shall continue to follow Regional EMS policies, Treatment Guidelines, and Scope of Practice.

G. The private physician may choose to offer assistance with another pair of eyes, hands, or suggestions; but allow the ALS personnel to operate under the direction of the base hospital, or the appropriate policies and procedures.

H. At all times the private physician is to be treated with respect and courtesy. Utilize the base hospital physician to resolve any challenges that arise and file an Unusual Occurrence report with your employer liaison.

V. State of California - California Medical Association, Note To Physician on Involvement With EMT-IIs and EMT-Ps (Paramedic):

STATE OF CALIFORNIA EMSA &

CALIFORNIA
MEDICAL
ASSOCIATION

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-Is AND PARAMEDICS

A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy. If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the Good Samaritan Code@ (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104).
(over)

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the Sate of California, and, if requested, showing proof of identity, you may choose one of the following:

1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support tram remain under base hospital control; or,

2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,

3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures.

(Whenever possible, remain in contact with the base station physician)

(REV. 7/88) 88 49638 Provided by the Emergency Medical Services Authority

POLICY: 570.35
TITLE: Refusal of EMS Service

EFFECTIVE: 11/1/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

REFUSAL OF EMS SERVICE

I. AUTHORITY

In accordance with Section 100147, Title 22 of the California Code of Regulations, H&S Code 1797.220 & Chapter 5 1798, the medical director of the local EMS Agency shall establish and maintain medical control.

II DEFINITIONS

A. **EMS Personnel**: All EMTs and Paramedics providing care within the Emergency Medical Services System.

B. **Emancipated Minor** means a person who is under the age of 18 who is married or who is determined by a court of competent jurisdiction to be legally able to care for him or herself.

C. **Person** means any individual encountered by EMS Personnel who does not manifest any overt evidence of illness or injury – AND – refuses any assessment by Emergency Medical Personnel.

D. **Basic Life Support Ambulance** means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

E. **Patient** means any individual encountered by EMS Personnel who demonstrates any of the following.

1. Suspected illness or injury
2. Involved in an event with significant mechanism that could cause illness or injury
3. Requests care or evaluation.
4. An altered level of consciousness

F. **Patient Relationship** exists because of EMS being summoned and EMS personnel coming into contact with a patient.

G. **Refusal of Service** applies to those patients who are refusing any EMS services provided by EMS Personnel including assessment, treatment, or transportation.

H. **5150** is defined in code as, "A patient who is held against their will for evaluation under the authority of Welfare and Institution Code, Section 5150, because the patient is a danger to themselves, a danger to others and/or gravely disabled (i.e., unable to care for self). This is a written order placed by a law enforcement officer, County Mental Health Worker, or a health worker certified by the County to place an individual on a 5150 hold."

I. **5170** is defined in code as, "A person who is a danger to others or to him/herself, or gravely disabled as a result of inebriation. A peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the County, or other person designated by the County may, upon reasonable cause, take or cause to be taken, the person into civil protective custody and place him in a facility designated by the County and approved by the State Department of Alcohol and Drug Abuse as a facility for 72-hour treatment and evaluation of inebriates."

III PURPOSE

To provide direction and guidelines to EMS Personnel for patient-initiated refusal of service.

IV. POLICY

A. Any patient may decline all or part of assessment, treatments, or transportation by EMS Personnel if the following factors are present:

1. The patient has the ability to communicate a choice.
2. The patient has the ability to understand the relevant information.
3. The patient has the ability to appreciate the situation and its consequences.
4. The patient has the ability to reason rationally.
5. The patient is an emancipated minor or over the age of 18.

B. When it is determined that a patient has refused assessment, treatment, or transport by ambulance, EMS personnel shall complete a refusal of EMS service form as developed by their respective employer.

C. EMT's conducting the Refusal of Service/AMA process must be operating in an Agency approved BLS Tiered Response system.

Example narrative: REFUSAL OF CARE AND TRANSPORT: The patient decided to refuse care which consisted of (Specify Care) and/or transport to the hospital of their choice. The patient was found alert and oriented to person, place, time, and situation at time of refusal. Further, we discussed several items that are consistent with someone who may demonstrate decisional capacity, such as; 1) Communicated a choice = The patient actively declined treatment and/or transport in their own words, 2) Understood relevant information = The patient expressed in their own words the medical crisis at hand and risks/benefits of medical treatment after discussion with Paramedic, 3) Appreciated the situation = The patient described their view of their medical condition and, 4) Reasoning about treatment/transport options = The patient's criterion for making their decision appeared reasonable. The appropriate signature was obtained on MVEMSA refusal of service form for this patient.

V. PROCEDURE

A. In the event a patient is refusing EMS services the EMS personnel with the highest medical authority on scene shall attempt the following:

1. Obtain a history of the event and prior medical history including medications.
2. Perform a physical assessment to include a complete set of vital signs and ensure that there are no life or limb threatening injuries or illnesses that would place this patient's life in jeopardy if left untreated.
3. You must give the patient enough information about the decision they are making so that there is informed consent. You must be satisfied that the patient has understood the risk and options concerning their decision.
4. Explain in detail the Medical Miranda Card as defined below:.

Patient Refusal Rights and Information

You are refusing medical treatment and/or transport. Your health and safety are our primary concern, please remember the following:

1. Our evaluation and/or treatment is not a substitute for medical evaluation and treatment by a doctor. We advise you to see a doctor or go to a hospital emergency department.

2. Your condition may not seem as bad to you as it is. Without treatment, your condition or problem could become worse.

3. If you change your mind or your condition becomes worse, please don't hesitate to call us back, by dialing 911. We will do our best to help you.

4. Don't wait! When medical treatment is needed, it's usually better to get it right away.

SPECIAL CONDITIONS:

5. Your condition has been discussed with a doctor at the hospital by radio or telephone and the advice given to you has been issued or approved by the doctor.

6. FOR MINORS: Instruct the patient's legal guardian that in this situation they are acting on behalf of the patient, and they understand the above information regarding refusal of treatment or transport and accept responsibility for the patient.

5. If a Basic Life Support Ambulance encounters a patient as defined in this policy and does not have a suspected ALS complaint, the EMTs shall complete the refusal of care process as outlined. If the patient is suspected to have an ALS complaint and refuses treatment and transport the EMT shall request an ALS ambulance, Paramedic supervisor or Paramedic QRV to complete the Refusal of Service process

B. For patients that are refusing part or all the assessment, treatment, or transportation and who in the judgment of the EMS personnel, requires assessment, treatment, or transportation, consider the following.

1. Have your partner offer assessment, treatment, or transportation.

2. Contact a designated base hospital for assistance from the base hospital physician in further assessment of the patient. Communication with the base physician may require communication between the physician and patient.
3. For a patient meeting "trauma criteria," a designated Trauma Center will be contacted in all cases of patient refusal of assessment, treatment, or transportation.
4. If the patient is a danger to themselves or others or meets the definition of a 5150 or 5170 patient, contact law enforcement officials.

C. Complete and explain the refusal of EMS service form to the patient.

1. A signature should be obtained from the patient and a witness if possible.
2. If patient is a minor or incompetent adult, assure that the legal guardian is refusing treatment prior to allowing the refusal.

D. Each item described above shall be documented on the prehospital care report (PCR) and filed per individual EMS service provider policy.

E. Provider Agencies will use the elements listed below on the EMS Service Patient Refusal Form:

1. Patient's Name, Age, Date, Incident Number, and Incident Location
2. Criteria for refusing care
3. Acknowledgement of Information
4. Release of Liability
5. Location for patient's signature and date
6. Check box for "refused to sign"
7. Witness signature line
8. Form completed by, signature line, date, and ID number

POLICY: 580.00
TITLE: Use of Patient Restraints

EFFECTIVE: 07/01/2024
REVIEW: 07/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

USE OF PATIENT RESTRAINTS

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.56; 1797.210 and; 1797.220. Title 22, California Code of Regulations, Section 100169(b)(7).

II DEFINITIONS

A. "Agency" means the Mountain Counties Emergency Medical Services Agency.

B. "Medical Restraint" means a physical restraint that is used to limit mobility or temporarily immobilize a patient for non-behavioral management reasons. (e.g., to promote healing by preventing the dislodgment of medical devices, or to protect a patient who is confused and/or disoriented and unable to follow instructions for their personal safety).

C. "Behavioral Restraint" means a physical restraint that is used to limit mobility or temporarily immobilize a patient who presents with a behavior crisis and poses an imminent threat to themselves or others.

D. "Approved Physical Restraint" means restraint equipment, supplies that have been approved by the Agency for use by prehospital care providers in the MCEMSA region.

E. "Chemical Restraint" means medication(s) that have been approved by the Agency for use when extreme agitation in a patient causes the application and/or maintenance of physical restraints too dangerous for prehospital care providers and/or the patient.

III PURPOSE

The purpose of this policy is.to establish procedures for use of patient restraints by Amador, Calaveras and Mariposa County prehospital care providers.

IV. POLICY

A. When restraints are necessary such activity will be undertaken in a manner that protects the patient's health and safely preserve his or her dignity, rights, and well being. The safety of the patient, community, and responding personnel is of paramount concern when following this policy.

B. Behavioral restraints are to be used only when necessary in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others. Only reasonable force sufficient to restrain the patient shall be used.

C. Chemical restraints are to be used with the utmost caution as they may cause respiratory depression/arrest or other adverse reactions in a patient, especially those with alcohol, medication or illicit drug use.

D. Chemical restraints may be used in conjunction with behavioral restraints.

E. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol intoxication, medication or illicit drug, metabolic disorder, stress, or psychiatric disorder. Appropriate treatment protocols shall be followed for suspected or identifiable medical conditions.

F. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

G. The following shall be documented o the patient care record:

1. The reason(s) restraints were used,

2. The providers and/or law enforcement agency that applied the restraint,

3. The type and the physiological location of the restraint device,

4. Documentation of assessment of circulatory and neurological status of all restrained extremities,

5. Documentation of assessment of respiratory status of restrained patient,

6. If chemical restrain is used; the dose, route and effect of the medication.

V. PROCEDURE

The following procedures should guide prehospital personnel in the application of restraints and the monitoring of a restrained patient.

A. If the patient is overly aggressive when prehospital personnel arrive on scene, they shall withdraw to a safe location and request law enforcement assistance.

B. Prehospital personnel shall not knowingly approach or attempt to remove a violent or emotionally disturbed patient from the scene without law enforcement present.

C. In a known violent situation, prehospital personnel should stand by until the scene is secured by law enforcement. At all times, when present, members of law enforcement are responsible for, and in control of, an emergency medical response involving a patient. exhibiting violent behavior, (i.e., emotional disturbed, drug related, etc.)

D. Prehospital personnel should avoid risks to themselves and the patient.

E. Adequate precautions shall be taken to protect prehospital personnel and the patient during the restraint process. Make certain that adequate personnel are available before attempting to restrain the patient.

F. Restraint equipment, applied by prehospital personnel, must be Agency approved and must allow for quick release.

G. The following forms of restraint shall NOT be used by prehospital personnel:

1. Hard plastic ties or any restraint device requiring a key to remove.

2. Sandwiching patients between backboards, scoop-stretchers, or flat, as a restraint.

3. Restraining a patient's hands and feet behind the patient, (i.e., hog-tying).

4. Methods or other materials applied in a manner that could cause respiratory, vascular, or neurological compromise, including prone restraints.

H. Restraint equipment applied by law enforcement (handcuffs, plastic ties, or hobble restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.

I. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and prehospital personnel safety. The officer should, if possible, accompany the patient in the ambulance, or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

J. Patients shall not be transported in a prone position unless required by a concomitant medical condition (e.g. impaled object preventing supine transport). Prehospital personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems and, does not preclude performing necessary medical interventions to protect the patient's airway should vomiting occur.

K. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve, and motor function at least every 15 minutes. II is recognized that the evaluation of nerve and motor status requires patient cooperation, and thus may be difficult or impossible to monitor.

POLICY: 620.10
TITLE: Quality Improvement Program

EFFECTIVE: 10/25/24
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

QUALITY IMPROVEMENT

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, Sections 1797.202, 1797.204, 1797.220, California Code of Regulations, Title 22, Division 9, Chapter 12, Sections 100400 – 100405, California Evidence Code, Section 1040, 1157, 1157.5, 1157.7

II DEFINITIONS

A. **Continuous Quality Improvement (CQI)** means an established committee, comprised of multiple provider agencies, which meets regularly to evaluate and act upon quality improvement information and issues within a local community.

B. **Mountain Counties Emergency Medical Services Agency (MCEMSA) Quality Improvement Program Manual** means the document which defines the standardized structure, process, and indicators to be used in performing quality improvement within the MCEMSA member counties' system.

C. **Outcome Indicator** means the result of structural and process indicators (e.g. cardiac arrest survival rate (outcome) compared to number of AEDs per population (structural) or response times (process).

D. **Process Indicator** means a measurable activity of a system (e.g. IV's, intubations)

E. **EMS Service Provider** means any agency which performs services directly or indirectly to a patient which has received pre-hospital care to include, but not be limited to: dispatch, first responder, ambulance, base hospitals, and receiving facilities.

F. **Provider Improvement Program** means a written program in which an EMS Provider has established an organizational structure and standard operating procedures which allow for the continual evaluation and improvement of services.

G. **Provider Quality Improvement Panel** means an established committee within a local EMS Provider organization which meets regularly to evaluate and act upon quality improvement information and issues within a local provider service area.

H. **Quality Improvement** means an organized and standardized process by which services and products delivered by an EMS System are continuously evaluated and improved based upon accepted benchmark standards.

I. **Quality Indicator** means a measurement of the degree or frequency of compliance with an established standard or benchmark, including both core indicators and ad-hoc indicators, as approved by the EMS Agency Medical Director.

J. **Quality Liaison Committee** (QLC) means an established committee of EMS service providers, which meets regularly to evaluate and act upon quality improvement information and standards within the regional service area.

K. **Structural Indicator** means a physical attribute of a system or the structures in place to ensure quality (e.g. number of hospital or ambulances per population).

III PURPOSE

To provide the structure and process for the continual evaluation and improvement of emergency medical care within the Mountain Counties EMS system.

IV. POLICY

The CQI program shall involve all system participants and shall include but not be limited to the following activities:

1. Prospective - designed to prevent potential problems.
2. Concurrent - designed to identify problems or potential problems during the delivery of patient care.
3. Retrospective - designed to identify problems or near misses and prevent their reoccurrence.
4. Reporting/feedback - all CQI activities shall be reported to the MCEMSA in a manner to be jointly determined. As a result of CQI activities, changes may be made affecting policy, guidelines, education, and/or the system.

A. Data Collection & System Evaluation

EMS Providers shall participate in an organized EMS system evaluation program at each of the following four levels:

1. Regional Level CQI (QLC)
   a. All EMS service providers shall collect and report data for core indicators to the MCEMSA on a regular basis, minimum quarterly.
   b. All EMS service providers shall collect and report ad-hoc indicators to the MCEMSA as recommended by the QLC and approved by the MCEMSA Medical Director.
   c. All EMS service providers shall participate in the regional QLC meetings and processes, which at a minimum provide review and assessment of structural, process, and outcome quality indicators as established within the regional EMS system.

2. Local Level CQI
   a. All EMS service providers shall collect and report data for core indicators to the MCEMSA on a regular basis in a method approved by the Agency.
   b. All EMS service providers shall collect and report ad-hoc indicators to the MCEMSA as recommended by the CQI and approved by the MCEMSA Medical Director.
   c. Each CQI shall regularly report the results of any system evaluation to the Quality Liaison Committee.
   d. All EMS service providers shall participate in the CQI meetings and processes, which at a minimum provide review and assessment of core

structural, processes, and outcome quality indicators as established within the regional EMS system.

3. Provider Level
   a. All EMS service providers shall establish in writing an internal Data Collection and System Evaluation program, which includes, at a minimum a:
      (1) list of structural, process, and outcome indicators, approved by the MCEMSA Medical Director
      (2) procedure for the evaluation of all established indicators
      (3) procedure for the regular reporting of core and ad-hoc indicators to the CQI, QLC, and MCEMSA
      (4) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to the provider QI liaison
      (5) procedure for reporting information on any structural, process, or outcome indicator which falls outside the accepted benchmarks to other agency provider QI liaisons when the information involves another EMS provider
      (6) procedure for submitting unusual occurrence reports (UOR) to the EMS agency for unresolved inter-agency issues.
   b. All providers shall immediately provide a written unusual occurrence report to the MCEMSA when any situation could be considered an imminent threat to the public health or safety.

4. Personnel level
   a. All EMS personnel who provide pre-hospital medical care for an EMS provider shall participate in a system evaluation program that includes, at a minimum:
      (1) collection and documentation of structural, process, and outcome indicators as established by the EMS service provider
      (2) periodic evaluation of established indicators
   b. All EMS personnel shall immediately provide a written situation report to the EMS Agency when any situation could be considered an imminent threat to the public health or safety or a time-sensitive near miss is recognized where expedient changes could prevent future problems.

B. **EMS System Improvement Program**

1. EMS Providers shall participate in an organized EMS system improvement program. In cooperation with the EMS agency, providers shall use the following four-step improvement process:
   a. **Plan:** Develop a PLAN to implement a policy, procedure, or process to improve quality.
   b. **Do:** After the plan is developed, DO it by putting the plan into action.

c. **Study**: After the plan has been put into action, STUDY the results to see if the plan has worked.

d. **Act:** After studying the results of the plan, ACT either to stabilize the improvement that occurred or to determine what went wrong if the gains that were planned for did not materialize.

2. EMS Providers shall participate in all training programs identified through the QI process for system improvement and approved by the MCEMSA Medical Director.

3. EMS Providers shall ensure that all personnel who provide prehospital medical care successfully complete training programs identified through the QI process for system improvement and are approved by the MCEMSA Medical Director. Training records shall be maintained for a period of not less than four years and be available to the MCEMSA upon request.

4. All EMS personnel who provide prehospital medical care shall participate in training programs identified through the QI process for system improvement and are approved by the MCEMSA Medical Director.

5. Each participating agency (Hospital, ALS, BLS, and dispatch) shall conduct an annual review of their CQI plan and submit changes or alterations to MCEMSA for approval.

6. All proceedings from the CQI committee and its subcommittees are confidential and protected under section 1157.7 of the evidence code: "The prohibition relating to discovery or testimony provided in Section 1157.7 shall be applicable to proceedings and records of any committee established by a local governmental agency to monitor, evaluate and report on the necessity, quality and level of specialty healthcare services, including but not limited to trauma care services, provided by a general acute care hospital which has been designated or recognized by that governmental agency as qualified to render specialty healthcare services."

Appendix A:

The following quality indicators shall be monitored and reported to MCEMSA on a regular basis:

1. Trauma scene times(goal < 10 minutes)
2. Medical scene times (goal < 15 minutes for STEMI, stroke, and sepsis and <20 minutes for other medical conditions)
3. Cardiac arrest survival rates
4. Trauma survival rates
5. AMA/RAS
6. Nature and frequency of Unusual Occurrence Reports
7. Pediatric survival rates
8. Successful IV after three attempts (goal > 90%)
9. Successful endotracheal placement or other form of airway management that facilitates successful ventilation after three attempts (goal 100%)
10. Sentinel events

POLICY: 620.20
TITLE: Unusual Occurrence Reporting

EFFECTIVE: 2/1/2025
REVIEW: 2/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

UNUSUAL OCCURRENCE REPORTING

I. **AUTHORITY:** California H&S Code, Division 2.5; CCR, Title 22, Division 9.

II. **PURPOSE:** To provide the EMS Agency and affected providers and hospitals, with a process to document and review problems related to policies, personnel performance issues, or other positive, negative, or unusual incidents. By submitting the Unusual Occurrence Report, the author assists the EMS Agency, provider agencies, and hospitals in improving the delivery of prehospital care. In order to correctly study, plan, and implement system improvements, significant events must be reported and tracked.

III. **DEFINITIONS:**

Unusual Occurrence is any occurrence or allegation of any of the following:

- Breech of the standard of care (failure to assess, undetected esophageal intubation, wrong medication, use of the wrong treatment guideline, etc.)
- Key equipment failure on a call directly related to the care of the patient.
- Event in which policy failed to provide guidance.
- Care beyond the appropriate scope of practice.
- Failure to follow MCEMSA policy.
- Suspected violations of Division 2.5 Health & Safety Code 1798.200.
- Any alleged or known injury to a patient because of actions by EMS personnel.

- Any recognition of exceptional effort or service provided by EMS personnel.

IV. POLICY:

EMS provider agencies and personnel shall report Unusual Occurrences to the EMS Agency following the procedure outlined in this policy within seventy-two (72) hours.

V. PROCEDURE

Any **Unusual Occurrence** as defined above, must be reported to the EMS agency utilizing them Mountain Counties EMS Agency Unusual Occurrence Report form 271.05 (See page 3). This form must be accompanied by any relevant documents that are available such as Prehospital Care Reports, complaint letters, etc.

a. Any agency or individual may submit an Unusual Occurrence Report.
   - Unusual Occurrence Reports may be submitted via fax, mail, email, or in person.
   - All Unusual Occurrence Reports referring to patient care issues must be accompanied by a PCR whenever possible.

b. Investigation and follow-up
   i. In all cases, Mountain Counties EMS Agency will be responsible for coordinating the investigation and follow-up.
   ii. Whenever possible, such investigations will be assigned to and conducted by the QI personnel of the involved agencies.
   iii. Following an inquiry and a complete review of the facts, the EMS Agency shall follow a Just Culture approach to manage the incident in one or more of the following ways:
      1. Record the incident and monitor to note any trends.
      2. Identify human error, at risk behavior, or reckless behavior and
         a. Identify any systems issues that can be modified to prevent recurrence and/or
         b. Work with the local provider to develop a coaching plan and/or
         c. Refer to the 240.00 Discipline for guidance on

actions

3. Recognize the exceptional effort of the EMS personnel.

MOUNTAIN COUNTIES EMS AGENCY
UNUSUAL OCCURRENCE REPORT

Incident:	(if appropriate, please complete)
Date _____ Time: _____	Patient: _____
Location: _____	PCR # _____
People present during incident: _____	Amb. Provider: _____
_____	Base Hospital: _____
_____	First Responder: _____
_____	

Narrative description of incident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(attach additional sheets as necessary)

Name of person submitting report: _____

Address: _____ Work Phone: _____

Home Phone: _____

Signature: _____ Date: _____

Please attach copies of any pertinent documents and submit to:

Mountain Counties Emergency Medical Services Agency
3505 Spangler Ln., Ste. 405, Copperopolis, CA 95228
(209) 529-5085 Fax (209) 529-1496

POLICY: 620.30
TITLE: Provider Agency Data Requirements

EFFECTIVE: 10/25/2024
REVIEW: 10/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Provider Agency Data Requirements

I. AUTHORITY

Health and Safety Code, Division 2.5, Section 1797.220

II DEFINITIONS

A. **Agency** means Mountain Counties EMS Agency

B. **CAD** means Computer Aided Dispatch

C. **CEMSIS** means California Emergency Medical Services Information System which currently uses the NEMSIS version 3 Data Dictionary System

D. **NEMSIS** means the National Emergency Medical Services Information System as defined by the NEMSIS Organization at www.nemsis.org

E. **ePCR** means Electronic Patient Care Report

F. **Provider Agency** means:
   1. A Communications Center that provides Emergency Medical Dispatch, including pre-arrival instructions or an Air Ambulance Dispatch Center, or;
   2. Pre-Hospital Care Agency that provides:
      a. Advanced Life Support First Response (also known as "First Response Advanced Life Support or FRALS) or;
      b. Limited Advanced Life Support (LALS) First Response or;
      c. A ground ambulance or;
      d. An air ambulance provider.

G. **XML** means Extensible Markup Language, a set of rules for encoding documents electronically.

III PURPOSE

To establish the standard data specifications for Computer Aided Dispatch and patient care records maintained by provider agencies for submission to Mountain Counties EMS Agency

IV. POLICY

A. Communication Centers shall submit CAD data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency. CAD data shall include records for all emergency and non-emergency ambulance requests received at the EMD Provider agency. Each computer dispatch record submitted to the Agency shall contain the following fields, as a minimum:

1. Call Date
2. Incident Number
3. Location
4. EMS Map Grid/Zone
5. Call Type (e.g. scene, inter-facility transfer)
6. Emergency Medical Dispatch (EMD) Determinate Code
7. Ambulance Provider
8. Vehicle ID Number
9. Time Call Received
10. Time Call Entered
11. Time Call in Dispatcher Queue
12. Time Dispatched
13. Time En Route
14. Time Arrived Scene
15. Time Patient Contact, if applicable
16. Time Departed Scene.
17. Time Arrived Destination.
18. Time canceled (if applicable)
19. Code of Response
20. Updated Code of Response, if applicable
21. Code of Transport
22. Updated Code of Transport, if applicable
23. Call Disposition, final result of the call for this vehicle or transport status

B. Pre-Hospital Care Agencies shall:

1. Submit ePCR data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency.

2. The ePCR shall include all fields listed in the most current version of the NEMSIS and/or CEMSISData Dictionary as defined by EMSA in document #101 “Required Elements State EMS Provider Agency Dataset” and #102 “Required Elements State EMS Call Dataset”. This dictionary shall be implemented beginning January 1, 2015

3. Comply with patient care record documentation requirements as specified in Agency Documentation Policy # 560.11

4. Use XML format as the approved data format by the Agency with respect to data structures, code sets (i.e. pick list values), and data export capabilities.

C. Agency reserves the right to add additional mandatory data elements as needed.

POLICY: 915.10
TITLE: Alternative Receiving Facility Kirkwood

EFFECTIVE: 8/15/2025
REVIEW: 8/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALTERNATIVE RECEIVING FACILITY KIRKWOOD

I. AUTHORITY
California Health and Safety Code 1798.101

II. DEFINITIONS

A. **Agency** means Mountain Counties Emergency Medical Services Agency (MCEMSA).

B. **Alternative Base Station/Hospital** means a facility or service operated and directly supervised by, or directly supervised by, a physician who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel, which has been approved by the medical director of the local EMS agency to provide medical direction to advanced life support or limited advanced life support personnel responding to a medical emergency as part of the local EMS system, when no qualified basic or comprehensive hospital is available to provide that medical direction.

C. **Alternate Receiving Facility** means a facility approved by the State Emergency Medical Services Authority, with the Medical Director of Mountain Counties EMS Agency, that authorizes patients to be transported to a facility which does not meet the requirement of a Receiving Facility in remote areas when the transport of a patient to a designated Receiving Facility, Base Hospital or Alternative Base Hospital is precluded due to geographic or other extenuating circumstances.

D. **Boundary** means the area in the Vail Resort Properties to include the Nordic Center.

E. **Clinic** refers to the Barton Medical Clinic at Kirkwood Ski Area.

F. **Prehospital Care Provider** means the ambulance service provider, fire service agency or any other emergency service provider that is authorized to provide prehospital care within the Agency. Any employee by the ski area is expected to follow their policies, procedures, and protocols.

III. PURPOSE
To establish the minimum requirements for an Alternative Receiving Facility, which shall provide medical control of prehospital emergency medical care provided for the area defined by the local EMS agency in accordance with policies and procedures.

IV. POLICY
A. The Agency shall designate Alternative Receiving Facilities to receive patients and provider medical care for injuries listed in MCEMS Policy # 915.10.

B. For Alternative Receiving Facilities, the Agency shall submit to the California State Emergency Medical Services Agency as part of its EMS plan, protocol approved by the Agency Medical Director to ensure that the use of that facility is in the best interest of patient care.

C. Any change in the status of an approved Alternative Receiving Facility to care for patients requiring emergency medical services, with respect to protocols and the facility's ability to care for patients shall be reported by the facility to MCEMSA immediately by phone to the Agency Duty Officer and by email to dutyofficer@mvemsa.com.

D. The protocols which govern the use of the facility shall consider, but not be limited to the following:

1. The medical staff and availability of the staff at various times to care for patients requiring emergency medical services.
2. The availability of more comprehensive emergency medical services and the distance and/or travel time necessary to make the alternative emergency medical services available.
3. The time of day and any limitations which may apply for the facility to assess and treat patients, requiring emergency medical services.

E. Patients at the Kirkwood Inn and/or Nordic Center and closer to the Kirkwood Ski Clinic shall be transported to the Clinic with the following conditions in the absence of signs of acute neurologic injury or illness such as head injury, new paralysis, and/or stroke:
1. Closed extremity injury
2. Lacerations
3. Time sensitive injury or illness that can benefit from services at the Clinic including but not limited to:
4. Cardiac arrest that does not meet TOR criteria per Cardiac Arrest policy #554.11 and Traumatic Arrest policy #554.83
5. Seizure
6. Chest pain suspicious for cardiac origin
7. Shortness of breath
8. Anaphylaxis

F. The following conditions **shall wait for or rendezvous with** ALS on scene unless waiting at the Clinic offers important benefits from inclement weather that supersede the ultimate longer transport to the hospital
1. Stroke
2. Head trauma with altered mental status
3. Acute paralysis
4. Open fractures or open dislocations

G. Patients may be transported to the Alternative Receiving Facility when the use of the facility is in the best interest of patient care.

V. DATA COLLECTION

A. Maintain a written Alternative Receiving Facility QI (Quality Improvement) policy or plan. This shall be submitted to MCEMSA on a yearly basis with an update.

B. Participate in the MCEMSA QI process.

C. Provide in a timely manner, data, and statistical reports as may reasonably be required by the Agency and as allowed under HIPPAA.

D. Maintain and oversee Alternative Receiving Facility physician and staff authorization

and CE tracking system.

VI. QUALITY ASSURANCE/IMPROVEMENT PROCESS

A. The Alternative Receiving Facility shall be monitored and evaluated by the Agency's Continuous Quality Improvement program.

B. The Agency shall notify the State EMS Authority of any reported complaints or unusual occurrences related to the Alternative Receiving Facility within 72 hours, which shall include all supporting documentation.

POLICY: 924.00
TITLE: Amador County BLS Tiered Response System

EFFECTIVE: 04/01/2022
REVIEW: 04/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Amador County BLS Tiered Response System

I. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.200

II DEFINITIONS

A. "Emergency Medical Dispatch" means a dispatch center that provides Emergency Medical Dispatch, including pre-arrival instructions, utilizing a card system approved by the EMS Agency Medical Director.

B. "Advanced Life Support Ambulance" means an emergency ambulance staffed with a minimum of one (1) Paramedic and one (1) Emergency Medical Technician (EMT)

C. "Basic Life Support Ambulance" means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III PURPOSE

To utilize Basic Life Support Ambulances in the 911 system for low acuity calls identified through the Emergency Medical Dispatch (EMD) process.

IV. POLICY

All Ambulance responses will be determined using the Medical Priority Dispatch System (MPDS) protocols and respond based on the level and mode of response approved by the Mountain Valley Emergency Medical Services Agency (MVEMSA) Medical Director.

V. PROCEDURE

A. MVEMSA authorized Emergency Medical Services Dispatch Center shall ensure that each request for ambulance service is managed in a manner consistent with established Agency policies, procedures, and the Medical Priority Dispatch System (MPDS) protocols.

B. A Basic Life Support Ambulance will be dispatched for service requests meeting the dispatch criteria using the MPDS and the Agency Medical Director approved level and mode of response.

C. Emergency Medical Technicians shall use the Mountain Valley Emergency Medical Services Agency approved policies, procedures, and protocols within their Scope of Practice to assess and treat patients when dispatched to a request for service. This shall include, but not be limited to documentation standards and Receiving Facility Radio Report.

D. If the patient assessment conducted by the Emergency Medical Technicians (Basic Life Support Ambulance) reveals a potentially unstable patient, the crew shall rendezvous with a paramedic resource (ALS Ambulance/ ALS Fire/Supervisor/QRV). If the time to rendezvous with a paramedic resource is greater than the estimated transport time to the closest receiving hospital, then the BLS crew shall transport to the closest receiving hospital. Transport mode, i.e., Code 2/3 is at the discretion of the transporting crew.

Potentially unstable adult patient:

- Cardiac Arrest
- Heart Rate < 50 or > 120
- Systolic Blood Pressure < 90mmHg
- Respiratory Rate > 24
- 02 sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate
- Any patient that meets trauma activation criteria per MVEMSA Policy
- 553.25 Trauma/Burn Triage and Patient Destination

Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.

1. Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
   - Tone
   - Interactiveness
   - Consolability
   - Look/gaze
   - Speech/cry

2. Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
   - Stridor
   - Wheezing
   - Grunting
   - Tripod positioning
   - Retractions
   - Nasal flaring
   - Apnea/gasping

3. Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
   - Pale
   - Mottled
   - Cyanotic

Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

E. If the patient refuses transport after assessment is completed, and/or any treatment provided, “Against Medical Advice” paperwork and process must be completed. Complete the process as outlined in MVEMSA policy 570.35 “Refusal of EMS Service.” ALS Fire shall NOT be requested specifically for the AMA process.

F. All transports involving the use of Basic Life Support Ambulance in the 911 system must be reviewed through the Quality Improvement Process at the ambulance provider level. Any case that needs further attention and review according to MVEMSA Policy 620.00, Unusual Occurrence Reporting shall be forwarded to the Quality Improvement Coordinator at MVEMSA.

G. The Emergency Medical Technician shall contact their immediate supervisor for any circumstances that may not be covered in this policy while responding to request for service, on scene of a request for service, and/or transporting to the receiving hospital.

POLICY: 944.10
TITLE: Mariposa County BLS Tiered Response System

EFFECTIVE: 07/01/2023
REVIEW: 07/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Mariposa County BLS Tiered Response System

I. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.200

II DEFINITIONS

A. "Emergency Medical Dispatch" means a dispatch center that provides Emergency Medical Dispatch, including pre-arrival instructions, utilizing a card system approved by the EMS Agency Medical Director.

B. "Advanced Life Support Ambulance" means an emergency ambulance staffed with a minimum of one (1) Paramedic and one (1) Emergency Medical Technician (EMT)

C. "Basic Life Support Ambulance" means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III PURPOSE

To utilize Basic Life Support Ambulances in the 911 system for low acuity calls identified through the Emergency Medical Dispatch (EMD) process.

IV. POLICY

All Ambulance responses will be determined using the Medical Priority Dispatch System (MPDS) protocols and respond based on the level and mode of response approved by the Mountain Counties Emergency Medical Services Agency (MCEMSA) Medical Director.

V. PROCEDURE

A. MCEMSA authorized Emergency Medical Services Dispatch Center shall ensure that each request for ambulance service is managed in a manner consistent with established Agency policies, procedures, and the Medical Priority Dispatch System (MPDS) protocols.

B. A Basic Life Support Ambulance will be dispatched for service requests meeting the dispatch criteria using the MPDS and the Agency Medical Director approved level and mode of response.

C. Emergency Medical Technicians shall use the Mountain Counties Emergency Medical Services Agency approved policies, procedures, and protocols within their Scope of Practice to assess and treat patients when dispatched to a request for service. This shall include, but not be limited to documentation standards and Receiving Facility Radio Report.

D. If the patient assessment conducted by the Emergency Medical Technicians (Basic Life Support Ambulance) reveals a potentially unstable patient, the crew shall rendezvous with a paramedic resource (ALS Ambulance/ ALS Fire/Supervisor/QRV). If the time to rendezvous with a paramedic resource is greater than the estimated transport time to the closest receiving hospital, then the BLS crew shall transport to the closest receiving hospital. Transport mode, i.e., Code 2/3 is at the discretion of the transporting crew.

Potentially unstable adult patient:

- Cardiac Arrest
- Heart Rate < 50 or > 120
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   - Tripod positioning
   - Retractions
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   - Apnea/gasping

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   - Pale
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Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

E. If the patient refuses transport after assessment is completed, and/or any treatment provided, "Against Medical Advice" paperwork and process must be completed. Complete the process as outlined in MCEMSA policy 570.35 "Refusal of EMS Service." ALS Fire shall NOT be requested specifically for the AMA process.

F. All transports involving the use of Basic Life Support Ambulance in the 911 system must be reviewed through the Quality Improvement Process at the ambulance provider level. Any case that needs further attention and review according to MCEMSA Policy 620.00, Unusual Occurrence Reporting shall be forwarded to the Quality Improvement Coordinator at MCEMSA.

G. The Emergency Medical Technician shall contact their immediate supervisor for any circumstances that may not be covered in this policy while responding to request for service, on scene of a request for service, and/or transporting to the receiving hospital.