DATE: April 25, 2013

TO: All S-SV EMS Field Providers and Personnel
    All S-SV EMS Base/Modified Base Hospitals

FROM: Vickie Pinette, Regional Executive Director
       Troy M. Falck MD, Medical Director

SUBJECT: S-SV EMS Agency Prehospital Care Policy Manual Update #50

EFFECTIVE DATE OF IMPLEMENTATION – June 1, 2013

Enclosed is the S-SV EMS Agency Policy Manual Update #50. Please note the following regarding this update packet:

- S-SV EMS Agency approved prehospital service providers are responsible for distribution of these updated policies and protocols to their personnel. Prehospital service providers are also responsible for providing any necessary orientation to all BLS, LALS & ALS field personnel regarding the provisions and requirements of these new and/or updated policies and protocols.

- Base/Modified Base Hospital Medical Directors and Base/Modified Base Hospital Coordinators are responsible for providing orientation to emergency department physicians and MICN personnel who provide online medical direction to prehospital personnel in the S-SV EMS region.

- The appropriate attached policies have been updated for consistency with the California Title 22 EMT & Paramedic Regulation revisions that became effective on April 1, 2013.

- The ALS/BLS (EMT & Paramedic) and LALS (Advanced EMT) treatment protocols are available as a separate file download on the “Medical Control Committee” page of the S-SV EMS Website (http://www.ssvems.com/?page_id=444).

- These new and/or updated S-SV EMS policies/protocols have the approval of S-SV EMS Agency committees, Regional Executive Director and the Medical Director. Therefore, all policies and procedures shall be strictly adhered to and are the basis for CQI activities.

- All policies and protocols included in S-SV EMS Policy Manual Update #50 will be updated on the S-SV EMS website (www.ssvems.com) prior to June 1, 2013.

Please feel free to contact the S-SV EMS Agency with any questions you may have regarding this update.
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<td>Advanced EMT: Base Hospital Medical Control Requirements</td>
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<td>AEMT &amp; Paramedic Service Provider Responsibilities</td>
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<td>911 Provider Response Policy</td>
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<td>911 Ambulance Service Provider Dispatch Requirements</td>
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<td>911 Ambulance Response Time Criteria</td>
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<td>911 Response Time Criteria - Placer County</td>
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<td>911 Response Time Criteria - Yolo County</td>
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<td>911 Response Time Criteria - Nevada County</td>
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<td>911 Response Time Criteria - Colusa County</td>
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<td>Tactical Medicine Operational Programs</td>
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<td>Auto Aid/Mutual Aid/Out-Of-Region Response</td>
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<td>Patient Destination</td>
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<td>Hospital Capabilities Reference</td>
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<td>Cardiovascular STEMI Receiving Centers</td>
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<td>Updated SRC facility requirements and prehospital patient destination language</td>
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<td>Emergency Department Downgrade and/or Cessation</td>
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<td>Prehospital Provider Agency Inventory Requirements</td>
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<td>LALS Service Provider Inventory</td>
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<td>BLS Ambulance Service Provider Inventory</td>
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<td>Prehospital Provider Agency Unit Inspections</td>
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<td>Management of Controlled Substances</td>
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<td>Additional language regarding incident notification and review requirements. New MCI Prehospital and Hospital Provider Critique Forms</td>
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<td>838</td>
<td>Crisis Standard of Care</td>
<td>Add</td>
<td>New policy and policy addendums</td>
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<td>Automatic Transport Ventilator Use During Interfacility Transports</td>
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<td>Trauma Triage Criteria</td>
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<td>Pulseless Arrest</td>
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<td>Return of Spontaneous Circulation (ROSC)</td>
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<td>Bradycardia</td>
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<td>C-8 &amp; C-8 (LALS)</td>
<td>Chest Pain or Suspected Symptoms of Cardiac Origin</td>
<td>Replace</td>
<td>Updated oxygen &amp; IV/IO fluid administration language. Clarification on patient destination</td>
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<td>R-1 &amp; R-1 (LALS)</td>
<td>Airway Obstruction</td>
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<td>Acute Respiratory Distress</td>
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<td>Allergic Reaction/Anaphylaxis</td>
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<td>Updated SBP definition parameters for patients in extremis. Updated IV fluid administration direction for patients not in anaphylaxis</td>
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<td>Phenothiazine/Dystonic Reaction</td>
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<td>Ingestions and Overdoses</td>
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<td>M-6 &amp; M-6 (LALS)</td>
<td>General Medical Treatment Protocol</td>
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<td>M-7</td>
<td>Nausea/Vomiting (From Any Cause)</td>
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<td>Updated language regarding prophylaxis administration of zofran. Updated zofran dosing. Updated fluid administration language</td>
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<td>Neonatal Resuscitation - Infants ≤ 28 Days Old</td>
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<td>Intraosseous Infusion Annual Skills Verification - Manual</td>
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### Adult Patient Treatment Protocols (BLS/ALS)

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- **C-5**  Return of Spontaneous Circulation (ROSC)  
- **C-6**  Tachycardia with Pulses  
- **C-7**  Bradycardia  
- **C-8**  Chest Pain or Suspected Symptoms of Cardiac Origin  

#### Respiratory

- **R-1**  Airway Obstruction  
- **R-2**  Respiratory Arrest  
- **R-3**  Acute Respiratory Distress  
- **R-3-A**  Continuous Positive Airway Pressure (CPAP)  

#### Medical

- **M-1**  Allergic Reaction/Anaphylaxis  
- **M-2**  Shock/Non-Traumatic Hypovolemia  
- **M-3**  Phenothiazine/Dystonic Reaction  
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- **M-5-A**  Guidelines for EMS Use of Activated Charcoal  
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Adult Patient Treatment Protocols (LALS)

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C-1 Pulseless Arrest
C-5 Return of Spontaneous Circulation (ROSC)
C-6 Tachycardia with Pulses
C-7 Bradycardia
C-8 Chest Pain or Suspected Symptoms of Cardiac Origin

Respiratory

R-1 Airway Obstruction
R-2 Respiratory Arrest
R-3 Acute Respiratory Distress
R-3-A Continuous Positive Airway Pressure (CPAP)

Medical

M-1 Allergic Reaction/Anaphylaxis
M-2 Shock/Non-Traumatic Hypovolemia
M-5 Ingestions & Overdoses
M-5-A Guidelines for EMS Use of Activated Charcoal
M-6 General Medical Treatment

Neurological

N-1 Altered Level of Consciousness
N-2 Seizure
N-3 Suspected CVA/Stroke
Obstetrics/Gynecology

OB/G-1 Childbirth

Environmental

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Article 1. Definitions

§ 100056. Automated External Defibrillator or AED.
“Automated external defibrillator” or AED means an external defibrillator capable of cardiac rhythm analysis that will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

§100056.1 EMT AED Service Provider.
An AED service provider means an agency or organization which is responsible for, and is approved to operate, an AED.

§100056.2 Manual Defibrillator.
“Manual Defibrillator” means a monitor/defibrillator that has no capability or limited capability for rhythm analysis and will charge and deliver a shock only at the command of the operator.

§ 100057. Emergency Medical Technician Approving Authority.
“Emergency Medical Technician (EMT) approving authority” means an agency or person authorized by this Chapter to approve an EMT training program, as follows:
(a) The EMT approving authority for an EMT training program conducted by a qualified statewide public safety agency shall be the director of the Emergency Medical Services Authority (Authority).
(b) The EMT approving authority for any other EMT training programs not included in subsection (a) shall be the local EMS agency (LEMSA) within that jurisdiction.

§100058. California EMT Certifying Entity.
“California EMT certifying entity”, or “EMT certifying entity”, or “certifying entity” means a public safety agency or the Office of the State Fire Marshal, if the agency has a training program for EMT personnel that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety Code, or the medical director of a LEMS A.

§ 100059. EMT Certifying Written Examination.
“EMT Certifying Written Examination” means the National Registry of Emergency Medical Technicians EMT-Basic Written Examination to test an individual applying for certification as an EMT. Examination results will be valid for application purposes two (2) years from the date of examination.

§ 100059.1. EMT Certifying Skills Examination
“Certifying Skills Examination” means the National Registry of Emergency Medical Technicians EMT-Basic Skills Examination to test an individual applying for certification as an EMT. Examination results will be valid for one (1) year for the purpose of being eligible for the National Registry of Emergency Medical Technicians EMT-Basic Written Examination.

§ 100059.2. EMT Optional Skills Medical Director.
“EMT Optional skills medical director” means a Physician and Surgeon licensed in California who is certified by or prepared for certification by either the American Board of Emergency Medicine or the Advisory Board for Osteopathic Specialties and is appointed by the LEMSA medical director to be responsible for any of the EMT Optional Skills that are listed in Section 100064 of this Chapter including medical control. Waiver of the board-certified requirement may be granted by the LEMSA medical director if such physicians are not available for approval.

§ 100060. Emergency Medical Technician.
“Emergency Medical Technician,” “EMT-Basic,” or “EMT” means a person who has successfully completed an EMT course that meets the requirements of this Chapter, has passed all required tests, and has been certified by a California EMT certifying entity.

§ 100061. EMT Local Accreditation.
“Local accreditation” or “accreditation” or “accredited to practice” as used in this Chapter, means authorization by the LEMSA to practice the optional skill(s) specified in Section 100064. Such authorization assures that the EMT has been oriented to the
LEMSA and trained in the optional skill(s) necessary to achieve the treatment standard of the jurisdiction.


§ 100061.1. Emergency Medical Services Quality Improvement Program.
"Emergency Medical Services Quality Improvement Program" or “EMSQIP” means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process, and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division. This is a model program which will develop over time and is to be tailored to the individual organization’s quality improvement needs and is to be based on available resources for the EMSQIP.


§ 100061.2. Authority
“Authority” means the Emergency Medical Services Authority.

Reference: Sections 1797.54 Health and Safety Code.

Article 2. General Provisions

§ 100062. Application of Chapter to Operation of Ambulances.
(a) Except as provided herein, the attendant on an ambulance operated in emergency service, or the driver if there is no attendant, shall possess a valid and current California EMT certificate. This requirement shall not apply during officially declared states of emergency and under conditions specified in Health and Safety Code, Section 1797.160.

(b) The requirements for EMT certification of ambulance attendants shall not apply, unless the individual chooses to be certified, to the following:
   (1) Physicians currently licensed in California.
   (2) Registered nurses currently licensed in California.
   (3) Physicians’ assistants currently licensed in California.
   (4) Paramedics currently licensed in California.
   (5) Advanced Emergency Medical Technicians (Advanced EMTs) currently certified in California.

(c) EMTs who are not currently certified in California may temporarily perform their scope of practice in California, when approved by the medical director of the LEMSA, in order to provide emergency medical services in response to a request, if all the following conditions are met:
   (1) The EMTs are registered by the National Registry of Emergency Medical Technicians or licensed or certified in another state or under the jurisdiction of a branch of the Armed Forces including the Coast Guard of the United States, National Park
Service, United States Department of the Interior-Bureau of Land Management, or the United States Forest Service; and
(2) The EMTs restrict their scope of practice to that for which they are licensed or certified.


§ 100063. Scope of Practice of Emergency Medical Technician.
(a) During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:
(1) Evaluate the ill and injured.
(2) Render basic life support, rescue and emergency medical care to patients.
(3) Obtain diagnostic signs to include, but not be limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.
(4) Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
(5) Administer oxygen.
(6) Use the following adjunctive airway and breathing aids:
   (A) Oropharyngeal airway;
   (B) Nasopharyngeal airway;
   (C) Suction devices;
   (D) Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
   (E) Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure.
(7) Use various types of stretchers and spinal immobilization devices.
(8) Provide initial prehospital emergency care of trauma, including, but not limited to:
   (A) Bleeding control through the application of tourniquets;
   (B) Use of hemostatic dressings from a list approved by the Authority;
   (C) Spinal immobilization;
   (D) Seated spinal immobilization;
   (E) Extremity splinting; and
   (F) Traction splinting.
(9) Administer over the counter medications when approved by the medical director of the LEMSA, including, but not limited to:
   (A) Oral glucose or sugar solutions; and
   (B) Aspirin.
(10) Extricate entrapped persons.
(11) Perform field triage.
(12) Transport patients.
(13) Mechanical patient restraint.
(14) Set up for ALS procedures, under the direction of an Advanced EMT or Paramedic.
(15) Perform automated external defibrillation.
(16) Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

(b) In addition to the activities authorized by subdivision (a) of this Section, the medical director of the LEMSA may also establish policies and procedures to allow a certified EMT or a supervised EMT student in the prehospital setting and/or during interfacility transport to:

1. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer’s lactate for volume replacement;
2. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;
3. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines; and
4. Monitor preexisting vascular access devices and intravenous lines delivering fluids with additional medications pre-approved by the Director of the Authority. Approval of such medications shall be obtained pursuant to the following procedures:
   (A) The medical director of the LEMSA shall submit a written request, Form #EMSA-0391, revised March 18, 2003, and obtain approval from the director of the Authority, who shall consult with a committee of LEMSA medical directors named by the Emergency Medical Services Medical Directors’ Association of California, Inc. (EMDAC), for any additional medications that in his/her professional judgment should be approved for implementation of Section 100063(b).
   (B) The Authority shall, within fourteen (14) working days of receiving the request, notify the medical director of the LEMSA submitting the request that the request has been received, and shall specify what information, if any, is missing.
   (C) The director of the Authority shall render the decision to approve or disapprove the additional medications within ninety (90) calendar days of receipt of the completed request.

(c) The scope of practice of an EMT shall not exceed those activities authorized in this Section, Section 100064, and Section 100064.1.


§100063.1. EMT AED Service Provider
An EMT AED service provider is an agency or organization that employs individuals as defined in Section 100060, and who obtain AEDs for the purpose of providing AED services to the general public.

(a) An EMT AED service provider shall be approved by the LEMSA, or in the case of state or federal agencies, the Authority, prior to beginning service. The Authority shall notify LEMSAs of state or federal agencies approved as EMT AED service providers. In order to receive and maintain EMT AED service provider approval, an EMT AED service provider shall comply with the requirements of this section.

(b) An EMT AED service provider approval may be revoked or suspended for failure to maintain the requirements of this section.
(c) An EMT AED service provider applicant shall be approved if they meet and provide the following:
(1) Provide orientation of AED authorized personnel to the AED;
(2) Ensure maintenance of AED equipment;
(3) Prior to January 1, 2002, ensure initial training and, thereafter, continued competency of AED authorized personnel;
(4) Collect and report to the LEMSA where the defibrillation occurred, as required by the LEMSA but no less than annually, data that includes, but is not limited to:
(A) The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
(B) The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed; and
(C) The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
(5) Authorize personnel and maintain a current listing of all EMT AED service providers authorized personnel and provide listing upon request to the LEMSA or the Authority.
(d) An approved EMT AED service provider and their authorized personnel shall be recognized statewide.
(e) Authorized personnel means EMT personnel trained to operate an AED and authorized by an approved EMT AED service provider.


§ 100064. EMT Optional Skills.
(a) In addition to the activities authorized by Section 100063 of this Chapter, LEMSA may establish policies and procedures for local accreditation of an EMT student or certified EMT to perform any or all of the following optional skills specified in this section.
(1) Accreditation for EMTs to practice optional skills shall be limited to those whose certificate is active and are employed within the jurisdiction of the LEMSA by an employer who is part of the organized EMS system.
(b) Use of perilaryngeal airway adjuncts.
(1) Training in the use of perilaryngeal airway adjuncts shall consist of not less than five (5) hours to result in the EMT being competent in the use of the device and airway control. Included in the above training hours shall be the following topics and skills:
(A) Anatomy and physiology of the respiratory system.
(B) Assessment of the respiratory system.
(C) Review of basic airway management techniques, which includes manual and mechanical.
(D) The role of the perilaryngeal airway adjuncts in the sequence of airway control.
(E) Indications and contraindications of the perilaryngeal airway adjuncts.
(F) The role of pre-oxygenation in preparation for the perilaryngeal airway adjuncts.
(G) Perilaryngeal airway adjuncts insertion and assessment of placement.
(H) Methods for prevention of basic skills deterioration.
(I) Alternatives to perilaryngeal airway adjuncts.
(2) At the completion of initial training, a student shall complete a competency-based written and skills examination for airway management which shall include the use of basic airway equipment and techniques and use of perilaryngeal airway adjuncts.

(3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.

(c) Administration of naloxone for suspected narcotic overdose.

(1) Training in the administration of naloxone shall consist of no less than two (2) hours to result in the EMT being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose. Included in the training hours listed above shall be the following topics and skills:

(A) Common causative agents
(B) Assessment findings
(C) Management to include but not be limited to:
(D) Need for appropriate personal protective equipment and scene safety awareness
(E) Profile of Naloxone to include, but not be limited to:
   1. Indications
   2. Contraindications
   3. Side/ adverse effects
   4. Routes of administration
   5. Dosages
(F) Mechanisms of drug action
(G) Calculating drug dosages
(H) Medical asepsis
(I) Disposal of contaminated items and sharps

(2) At the completion of this training, the student shall complete a competency based written and skills examination for administration of naloxone which shall include:

(A) Assessment of when to administer naloxone,
(B) Managing a patient before and after administering naloxone,
(C) Using universal precautions and body substance isolation procedures during medication administration,
(D) Demonstrating aseptic technique during medication administration,
(E) Demonstrate preparation and administration of parenteral medications by a route other than intravenous.
(F) Proper disposal of contaminated items and sharps.

(3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.

(d) Administration of epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma.

(1) Training in the administration of epinephrine shall consist of no less than two (2) hours to result in the EMT being competent in the administration of epinephrine and managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms. Included in the training hours listed above shall be the following topics and skills:

(A) Common causative agents
(B) Assessment findings
(C) Management to include but not be limited to:
(D) Need for appropriate personal protective equipment and scene safety awareness
(E) Profile of epinephrine to include, but not be limited to:
   1. Indications
   2. Contraindications
   3. Side/ adverse effects
   4. Administration by auto-injector
   5. Dosages
   6. Mechanisms of drug action
(F) Medical asepsis
(H) Disposal of contaminated items and sharps
(2) At the completion of this training, the student shall complete a competency based written and skills examination for administration of epinephrine which shall include:
   (A) Assesment of when to administer epinephrine,
   (B) Managing a patient before and after administering epinephrine,
   (C) Using universal precautions and body substance isolation procedures during medication administration,
   (D) Demonstrating aseptic technique during medication administration,
   (E) Demonstrate preparation and administration of epinephrine by auto-injector.
   (F) Proper disposal of contaminated items and sharps.
(3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.
(e) Administer the medications listed in this subsection.
(1) Using prepackaged products, the following medications may be administered:
   (A) Atropine
   (B) Pralidoxime Chloride
(2) This training shall consist of no less than two (2) hours of didactic and skills laboratory training. In addition basic weapons of mass destruction training is recommended.
   (A) Indications
   (B) Contraindications
   (C) Side/ adverse effects
   (D) Routes of administration
   (E) Dosages
   (F) Mechanisms of drug action
   (G) Disposal of contaminated items and sharps
   (H) Medication administration.
(3) At the completion of this training, the student shall complete a competency based written and skills examination for the administration of medications listed in this subsection which shall include:
   (A) Assessment of when to administer these medications,
   (B) Managing a patient before and after administering these medications,
   (C) Using universal precautions and body substance isolation procedures during medication administration,
   (D) Demonstrating aseptic technique during medication administration,
   (E) Demonstrate the preparation and administration of medications by the intramuscular
route,
(F) Proper disposal of contaminated items and sharps.
(4) A LEMSA shall establish policies and procedures for skills competency
demonstration that requires the accredited EMT to demonstrate skills competency at
least every two (2) years, or more frequently as determined by EMSQIP.
(f) The medical director of the LEMSA shall develop a plan for each optional skill
allowed. The plan shall, at a minimum, include the following:
(1) A description of the need for the use of the optional skill.
(2) A description of the geographic area within which the optional skill will be utilized,
except as provided in Section 100064(l).
(3) A description of the data collection methodology which shall also include an
evaluation of the effectiveness of the optional skill.
(4) The policies and procedures to be instituted by the LEMSA regarding medical
control and use of the optional skill.
(5) The LEMSA shall develop policies for accreditation action, pursuant to Chapter 6 of
this Division, for individuals who fail to demonstrate competency.
(g) A LEMSA medical director who accredits EMTs to perform any optional skill shall:
(1) Establish policies and procedures for the approval of service provider(s) utilizing
approved optional skills.
(2) Approve and designate selected base hospital(s) as the LEMSA deems necessary
to provide direction and supervision of accredited EMTs in accordance with policies and
procedures established by the LEMSA.
(3) Establish policies and procedures to collect, maintain and evaluate patient care
records.
(4) Establish an EMSQIP. EMSQIP means a method of evaluation of services
provided, which includes defined standards, evaluation of methodology(ies) and
utilization of evaluation results for continued system improvement. Such methods may
include, but not be limited to, a written plan describing the program objectives,
organization, scope and mechanisms for overseeing the effectiveness of the program.
(5) Establish policies and procedures for additional training necessary to maintain
accreditation for each of the optional skills contained in this section, if applicable.
(h) The LEMSA medical director may approve an optional skill medical director to be
responsible for accreditation and any or all of the following requirements.
(1) Approve and monitor training programs for optional skills including refresher training
within the jurisdiction of the LEMSA.
(2) Establish policies and procedures for continued competency in the optional skill
which will consist of organized field care audits, periodic training sessions and/or
structured clinical experience.
(i) The optional skill medical director may delegate the specific field care audits,
training, and demonstration of competency, if approved by the LEMSA medical director,
to a Physician, Registered Nurse, Physician Assistant, Paramedic, or Advanced EMT,
licensed or certified in California or a physician licensed in another state immediately
adjacent to the LEMSA jurisdiction.
(j) An EMT accredited in an optional skill may assist in demonstration of competency
and training of that skill.
(k) In order to be accredited to utilize an optional skill, an EMT shall demonstrate
competency through passage, by pre-established standards, developed and/or
approved by the LEMSA, of a competency-based written and skills examination which
tests the ability to assess and manage the specified condition.
(l) During a mutual aid response into another jurisdiction, an EMT may utilize the scope
of practice for which s/he is trained, certified and accredited according to the policies
and procedures established by his/her certifying or accrediting LEMSA.
Reference: Sections 1797.8, 1797.52, 1797.58, 1797.90, 1797.170, 1797.173,
1797.175, 1797.176, 1797.202, 1797.208, 1797.212, 1798, 1798.2, 1798.100, 1798.102

§ 100064.1. EMT Trial Studies.
An EMT may perform any prehospital emergency medical care treatment procedure(s)
or administer any medication(s) on a trial basis when approved by the medical director
of the LEMSA and the director of the Authority. The medical director of the LEMSA
shall review the medical literature on the procedure or medication and determine in
his/her professional judgment whether a trial study is needed.
(a) The medical director of the LEMSA shall review a trial study plan which, at a
minimum, shall include the following:
(1) A description of the procedure(s) or medication(s) proposed, the medical conditions
for which they can be utilized, and the patient population that will benefit.
(2) A compendium of relevant studies and material from the medical literature.
(3) A description of the proposed study design, including the scope of study and
method of evaluating the effectiveness of the procedure(s) or medication(s), and
expected outcome.
(4) Recommended policies and procedures to be instituted by the LEMSA regarding
the use and medical control of the procedure(s) or medication(s) used in the study.
(5) A description of the training and competency testing required to implement the
study. Training on subject matter shall be consistent with the related topic(s) and skill(s)
specified in Section 100159, Chapter 4 (Paramedic regulations), Division 9, Title 22,
California Code of Regulations.
(b) The medical director of the LEMSA shall appoint a local medical advisory committee
to assist with the evaluation and approval of trial studies. The membership of the
committee shall be determined by the medical director of the LEMSA, but shall include
individuals with knowledge and experience in research and the effect of the proposed
study on the EMS system.
(c) The medical director of the LEMSA shall submit the proposed study and a copy of
the proposed trial study plan at least forty-five (45) calendar days prior to the proposed
initiation of the study to the director of the Authority for approval in accordance with the
provisions of Section 1797.221 of the Health and Safety Code. The Authority shall
inform the Commission on EMS of studies being initiated.
(d) The Authority shall notify the medical director of the LEMSA submitting its request
for approval of a trial study within fourteen (14) working days of receiving the request
that the request has been received.
(e) The Director of the Authority shall render the decision to approve or disapprove the
trial study within forty-five (45) calendar days of receipt of all materials specified in
subsections (a) and (b) of this section.
Effective April 1, 2013

(f) Within eighteen (18) months of the initiation of the procedure(s) or medication(s), the medical director of the LEMSA shall submit to the Commission on EMS a written report which includes at a minimum the progress of the study, number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(g) The Commission on EMS shall review the above report within two (2) meetings and advise the Authority to do one of the following:
   (1) Recommend termination of the study if there are adverse effects or if no benefit from the study is shown.
   (2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential but inconclusive benefit is shown.
   (3) Recommend the procedure or medication be added to the EMT scope of practice.

(h) If option (g)(2) is selected, the Commission on EMS may advise continuation of the study as structured or alteration of the study to increase the validity of the results.

(i) At the end of the additional eighteen (18) month period, a final report shall be submitted to the Commission on EMS with the same format as described in (f) above.

(j) The Commission on EMS shall review the final report and advise the Authority to do one of the following:
   (1) Recommend termination or further extension of the study.
   (2) Accept the study recommendations.
   (3) Recommend the procedure or medication be added to the EMT scope of practice.

(k) The Authority may require a trial study(ies) to cease after thirty-six (36) months.


Article 3. Program Requirements for EMT Training Programs

§ 100065. Approved Training Programs
(a) The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.
(b) EMT training may be offered only by approved training programs. Eligibility for program approval shall be limited to:
   (1) Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.
   (2) Medical training units of a branch of the Armed Forces including the Coast Guard of the United States.
   (3) Licensed general acute care hospitals which meet the following criteria:
      (A) Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5; and
      (B) Provide continuing education to other health care professionals.
   (4) Agencies of government including public safety agencies.
   (5) LEMSAs.

§100066. Procedure for EMT Training Program Approval.
(a) Eligible training programs may submit a written request for EMT program approval to an EMT approving authority.
(b) The EMT approving authority shall review and approve the following prior to approving an EMT training program:
   (2) A statement verifying CPR training equivalent to the current American Heart Association’s Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course.
   (3) Samples of written and skills examinations used for periodic testing.
   (4) A final skills competency examination.
   (5) A final written examination.
   (6) The name and qualifications of the program director, program clinical coordinator, and principal instructor(s).
   (7) Provisions for clinical experience, as defined in Section 100068 of this Chapter.
   (8) Provisions for course completion by challenge, including a challenge examination (if different from final examination).
   (9) Provisions for a twenty-four (24) hour refresher course including subdivisions (1)-(6) above, required for recertification.
   (10) The location at which the courses are to be offered and their proposed dates.
   (11) Table of contents listing the required information listed in this subdivision, with corresponding page numbers.
(c) In addition to those items listed in subdivision (b) of this Section, the Authority shall assure that a statewide public safety agency meets the following criteria in order to approve that agency as qualified to conduct a statewide EMT training program:
   (1) Has a statewide role and responsibility in matters affecting public safety.
   (2) Has a centralized authority over its EMT training program instruction which can correct any elements of the program found to be in conflict with this Chapter.
   (3) Has a management structure which monitors all of its EMT training programs.
   (4) Has designated a liaison to the Authority who shall respond to problems or conflicts identified in the operation of its EMT training program.
   (5) In addition, these agencies shall meet the following additional requirements:
   (A) Designate the principal instructor as a liaison to the EMT approving authority for the county in which the training is conducted; and
   (B) Consult with the EMT approving authority for the county in which the training is located in developing the EMS System Orientation portion of the EMT course.
(d) The EMT approving authority shall make available to the Authority, upon request, any or all materials submitted pursuant to this Section by an approved EMT training program in order to allow the Authority to make the determination required by Section 1797.173 of the Health and Safety Code.


§ 100067. Didactic and Skills Laboratory.
An approved EMT training program shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during skills practice/laboratory sessions.


§ 100068. Clinical Experience for EMT.
Each approved EMT training program shall have written agreement(s) with one or more general acute care hospital(s) and/or operational ambulance provider(s) or rescue vehicle provider(s) for the clinical portion of the EMT training course. The written agreement(s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s). Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience.


§ 100069. EMT Training Program Notification.
(a) In accordance with Section 100057 the EMT Approving Authority shall notify the training program submitting its request for training program approval within seven (7) working days of receiving the request that:
   (1) The request has been received,
   (2) The request contains or does not contain the information requested in Section 100066 of this Chapter and,
   (3) What information, if any, is missing from the request.
(b) Program approval or disapproval shall be made in writing by the EMT approving authority to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed three (3) months.
(c) The EMT approving authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
(d) Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program
effective the same date as the EMT training program approval. The CE program expiration date shall be the same expiration date as the EMT training program. The CE provider shall comply with all of the requirements contained in Chapter 11 of this Division.

(f) The LEMSA shall notify the Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, frequency and cost for both basic and refresher courses, student eligibility, and program approval/expiration date of program approval.


§ 100070. Teaching Staff.
Each EMT training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this section precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions of this section:

(a) Each EMT training program shall have an approved program director who shall be qualified by education and experience in methods, materials, and evaluation of instruction which shall be documented by at least forty (40) hours in teaching methodology. The courses include but are not limited to the following examples:

1. State Fire Marshal Instructor 1A and 1B,
2. National Fire Academy’s Instructional Methodology,
3. Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.

(b) Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to:

1. Administering the training program.
2. Approving course content.
3. Approving all written examinations and the final skills examination.
4. Coordinating all clinical and field activities related to the course.
5. Approving the principal instructor(s) and teaching assistants.
6. Signing all course completion records.
7. Assuring that all aspects of the EMT training program are in compliance with this Chapter and other related laws.

(c) Each training program shall have an approved program clinical coordinator who shall be either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:

1. Responsibility for the overall quality of medical content of the program;
2. Approval of the qualifications of the principal instructor(s) and teaching assistant(s).
(d) Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. The courses include but are not limited to the following examples:
(1) State Fire Marshal Instructor 1A and 1B,
(2) National Fire Academy’s Instructional Methodology,
(3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
and who shall:
(A) Be a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California; or,
(B) Be an Advanced EMT or EMT who is currently certified in California.
(C) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
(D) Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned. All principal instructors from approved EMT Training Programs shall meet the minimum qualifications as specified in subsection (d) of this Section.
(e) Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.

§ 100071. EMT Training Program Review and Reporting.
(a) All program materials specified in this Chapter shall be subject to periodic review by the EMT approving authority.
(b) All programs shall be subject to periodic on-site evaluation by the EMT approving authority.
(c) Any person or agency conducting a training program shall notify the EMT approving authority in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in, program director, program clinical coordinator, principal instructor, change of address, phone number, and contact person.
(d) For the purposes of this Chapter, student records shall be kept for a period of not less than four (4) years.

§ 100072. Withdrawal of EMT Training Program Approval.
(a) Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of
this Chapter may result in denial, probation, suspension or revocation of program approval by the EMT training program approving authority. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

(1) An EMT training program approving authority shall notify the approved EMT training program course director in writing, by registered mail, of the provisions of this Chapter with which the EMT training program is not in compliance.

(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved EMT training program shall submit in writing, by registered mail, to the EMT training program approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) working days of receipt of the response from the approved EMT training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMT training program, the EMT training program approving authority shall notify the Authority and the approved EMT training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the EMT training program approval.

(4) If the EMT training program approving authority decides to suspend, revoke, or place an EMT training program on probation the notification specified in subsection (a)(3) of this section shall include the beginning and ending dates of the probation or suspension and the 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) calendar days from the date of the EMT training program approving authority’s letter of decision to the Authority and the EMT training program.


§ 100073. Components of an Approved Program.

(a) An approved EMT training program shall consist of all of the following:

(1) The EMT course, including clinical experience;

(2) Periodic and a final written and skill competency examinations;

(3) A challenge examination; and

(4) A refresher course required for recertification.

(b) The LEMSA may approve a training program that offers only refresher course(s).


§ 100074. EMT Training Program Required Course Hours.

(a) The EMT course shall consist of not less than one-hundred sixty (160) hours. These training hours shall be divided into:

(1) A minimum of one hundred thirty-six (136) hours of didactic instruction and skills laboratory; and
(2) A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated.

(3) Existing EMT training programs approved prior to the effective date of this chapter shall have a maximum of twelve (12) months from the date that this provision becomes effective to meet the minimum hourly requirements specified in this Section.

(b) The minimum hours shall not include the examinations for EMT certification.


§100075. Required Course Content.
(a) The content of an EMT course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), incorporated herein by reference, to result in the EMT being competent in the EMT basic scope of practice specified in Section 100063 of this Chapter. The U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009) can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address: http://ems.gov/pdf/811077a.pdf

(b) Training in the use of hemostatic dressings shall consist of not less than one (1) hour to result in the EMT being competent in the use of the dressing. Included in the training shall be the following topics and skills:

(1) Review of basic methods of bleeding control to include but not be limited to direct pressure, pressure bandages, tourniquets, and hemostatic dressings;

(2) Review treatment of open chest wall injuries;

(3) Types of hemostatic dressings; and

(4) Importance of maintaining normal body temperature.

(c) At the completion of initial training, a student shall complete a competency-based written and skills examination for controlling bleeding and the use of hemostatic dressings.


§ 100076. Required Testing.
Each component of an approved program shall include periodic and final competency-based examinations to test the knowledge and skills specified in this Chapter. Satisfactory performance in these written and skills examinations shall be demonstrated for successful completion of the course. Satisfactory performance shall be determined by pre-established standards, developed and/or approved by the EMT approving authority pursuant to Section 100066 of this Chapter.


§ 100077. EMT Training Program Course Completion Record.
(a) An approved EMT training program provider shall issue a tamper resistant course completion record to each person who has successfully completed the EMT course, refresher course, or challenge examination.
(b) The course completion record shall contain the following:
   (1) The name of the individual.
   (2) The date of course completion.
   (3) Type of EMT course completed (i.e., EMT, refresher, or challenge), and the number of hours completed.
   (4) The EMT approving authority.
   (5) The signature of the program director.
   (6) The name and location of the training program issuing the record.
   (7) The following statement in bold print: “This is not an EMT certificate”.
(c) This course completion record is valid to apply for certification for a maximum of two (2) years from the course completion date and shall be recognized statewide.
(d) The name and address of each person receiving a course completion record and the date of course completion shall be reported in writing to the appropriate EMT certifying authority within fifteen (15) working days of course completion.
(e) Approved EMT training programs which are also approved EMT Certifying Entities need not issue a Course Completion record to those students who will receive certification from the same agency.


§100078. EMT Training Program Course Completion Challenge Process.
(a) An individual may obtain an EMT course completion record from an approved EMT training program by successfully passing by pre-established standards, developed and/or approved by the EMT approving authority pursuant to Section 100066 of this Chapter, a course challenge examination if s/he meets one of the following eligibility requirements:
   (1) The individual is currently licensed in the United States as a Physician, Registered Nurse, Physician Assistant, Vocational Nurse, or Licensed Practical Nurse.
   (2) The individual provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces of the United States within the preceding two (2) years that meets the U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009). Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete CE courses as a condition of certification.
(b) The course challenge examination shall consist of a competency-based written and skills examination to test knowledge of the topics and skills prescribed in this Chapter.
(c) An approved EMT training program shall offer an EMT challenge examination no less than once each time the EMT course is given (unless otherwise specified by the program’s EMT approving authority).
(d) An eligible individual shall be permitted to take the EMT course challenge examination only one (1) time.
(e) An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.


Article 4. EMT Certification

§100079. EMT Initial Certification Requirements.
(a) An individual who meets one of the following criteria shall be eligible for initial certification upon fulfilling the requirements of subdivision (b) of this Section:
(1) Pass the written examination and skills examination specified in Sections 100059 and 100059.1 of this Chapter and have either:
(A) A valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100066 of this Chapter dated within the last two (2) years,
(B) Documentation of successful completion of an approved out-of-state initial EMT training course, within the last two (2) years, that meets the requirements of this Chapter, or
(C) A current and valid out-of-state EMT certificate.
(2) Possess a current and valid National Registry EMT-Basic registration certificate.
(3) Possess a current and valid out-of-state or National Registry EMT-Intermediate or Paramedic certificate.
(4) Possess a current and valid California Advanced EMT or EMT-II certification or a current and valid California Paramedic license.
(b) In addition to meeting one of the criteria listed in subdivision (a), to be eligible for initial certification, an individual shall:
(1) Be eighteen (18) years of age or older;
(2) Complete the criminal history background check requirement as specified in Article 4, Chapter 10 of this Division;
(3) Complete an application form that contains this statement: “I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California.”;
(4) Disclose any certification or licensure action:
(A) Against an EMT, Advanced EMT, or EMT-II certificate, or any denial of certification by a LEMSA, including any active investigations;
(B) Against a Paramedic license, or any denial of licensure by the Authority, including any active investigations;
(C) Against any EMS-related certification or license of another state or other issuing entity, including any active investigations; or
(D) Against any health-related license.
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(5) Pay the established fee.
(c) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five (45) days to eligible individuals who apply for an EMT certificate and successfully complete the requirements of this Chapter.
(d) The effective date of initial certification shall be the day the certificate is issued.
(e) The expiration date for an initial EMT certificate shall be as follows:
(1) For an individual who meets the criteria listed in subdivisions (a)(1)(A) or (a)(1)(B) of this Section, the expiration date shall be the last day of the month two (2) years from the effective date of the initial certification.
(2) For an individual who meets the criteria listed in subdivisions (a)(1)(C), (a)(2), (a)(3) or (a)(4) of this Section, the expiration date shall be the lesser of the following:
(A) The last day of the month two (2) years from the effective date of the initial certification;
or
(B) The expiration date of the certificate or license used to establish eligibility under subdivision (a) of this Section.
(f) The EMT shall be responsible for notifying the certifying entity of her/his proper and current mailing address and shall notify the certifying entity in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and EMT registry number.
(g) An EMT shall only be certified by one (1) certifying entity during a certification period.


Article 5. Maintaining EMT Certification and Recertification

§100080. EMT Recertification.
(a) In order to recertify, an EMT shall:
(1) Possess a current EMT Certification issued in California.
(2) Obtain at least twenty-four (24) hours of continuing education hours (CEH) from an approved CE provider in accordance with the provisions contained in Chapter 11 of this Division, or successfully complete a twenty-four (24) hour refresher course from an approved EMT training program. An individual who is currently licensed in California as a Paramedic or certified as an Advanced EMT or EMT-II, or who has been certified within six (6) months of the date of application, may be given credit for CEH earned as a Paramedic, Advanced EMT or EMT-II to satisfy the CE requirement for EMT recertification as specified in this Chapter.
(3) Complete an application form and other processes as specified in Section 100079, subdivisions (b)(3)-(b)(5), of this Chapter.
(4) Complete the criminal history background check requirements as specified in Article 4, Chapter 10 of this Division.
(5) Submit a completed skills competency verification form, EMSA-SCV (08/10). Form EMSA-SCV (08/10) is herein incorporated by reference. Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an individual who is currently certified or licensed as an
EMT, AEMT, Paramedic, Registered Nurse, Physician’s Assistant, or Physician and who shall be designated by an EMS approved training program (EMT training program, AEMT training program, Paramedic training program or CE provider) or an EMS service provider. EMS service providers include, but are not limited to, public safety agencies, private ambulance providers and other EMS providers. Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.

(b) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five (45) days to eligible individuals who apply for EMT recertification and successfully complete the requirements of this Chapter.

(c) If the EMT recertification requirements are met within six (6) months prior to the current certification expiration date, the EMT Certifying entity shall make the effective date of recertification the date immediately following the expiration date of the current certificate. The certification will expire two (2) years from the day prior to the effective date.

(d) If the EMT recertification requirements are met greater than six (6) months prior to the expiration date, the EMT Certifying entity shall make the effective date of recertification the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date will be the last day of the month two (2) years from the effective date.

(e) A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5). In order to qualify for this exception, the individual shall submit proof of their membership in the Armed Forces of the United States and documentation of their deployment starting and ending dates. Continuing education credit may be given for documented training that meets the requirements of Chapter 11 of this Division while the individual was deployed on active duty. The documentation shall include verification from the individual’s Commanding Officer attesting to the training attended.


§100081. Recertification of an Expired California EMT Certificate.

(a) The following requirements apply to individuals who wish to be eligible for recertification after their California EMT Certificates have expired:

(1) For a lapse of less than six (6) months, the individual shall complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5).

(2) For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall:

(A) Complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5), and

(B) Complete an additional twelve (12) hours of continuing education.
(3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall:
(A) Complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5), and
(B) Complete an additional twenty-four (24) hours of continuing education, and
(C) Pass the written and skills certification exams as specified in Sections 100059 and 100059.1.
(4) For a lapse of greater than twenty-four (24) months the individual shall meet the
requirements of Section 100079, subdivisions (a) and (b).
(b) For individuals who meet the requirements of Section 100081, subdivision (a)(1),
(a)(2), or (a)(3), the EMT certifying entity shall make the effective date of recertification
the day the certificate is issued. The certification expiration date will be the last day of
the month two (2) years from the effective date. For individuals who meet the
requirements of Section 100081, subdivision (a)(4), the EMT certifying entity shall make
the certification effective and expiration dates consistent with Section 100079,
subdivisions (d) and (e).
(c) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to
Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five
(45) days to eligible individuals who apply for EMT recertification and successfully
complete the requirements of this Chapter.
NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health
and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.109, 1797.118,
1797.170, 1797.175, 1797.184, 1797.210 and 1797.216, Health and Safety Code; and
United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

Article 6. Record Keeping and Fees

§ 100082. Record Keeping.
(a) Each EMT approving authority shall maintain a list of approved training programs
within its jurisdiction and provide the Authority with a copy. The Authority shall be
notified of any changes in the list of approved training programs as such occur.
(b) Each EMT approving authority shall maintain a list of current EMT program
directors, clinical coordinators and principal instructors within its jurisdiction.
(c) The Authority shall maintain a record of approved EMT training programs.
(d) A LEMSA may develop policies and procedures which require basic life support
services to make available the records of calls maintained in accordance with Section
1100.7, Title 13 of the California Code of Regulations.
NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health
and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.109, 1797.118,
1797.170, 1797.173, 1797.200, 1797.202, 1797.204, 1797.208, 1797.211 and 1797.220, Health
and Safety Code.

§ 100083. Fees.
A LEMSA may establish a schedule of fees for EMT training program review, approval,
EMT certification and EMT recertification in an amount sufficient to cover the
reasonable cost of complying with the provisions of this Chapter.

THIS REGULATION WAS SUPPORTED BY THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF CDC.
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Article 1. Definitions

§ 100135. Approved Testing Agency.
"Approved Testing Agency" means an agency approved by the Emergency Medical Services Authority (Authority) to administer the licensure examination.

§ 100136. Emergency Medical Services System Quality Improvement Program.
"Emergency Medical Services System Quality Improvement Program" or "EMSQIP" means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division. This is a model program which will develop over time and is to be tailored to the individual organization’s quality improvement needs and is to be based on available resources for the EMSQIP.

§ 100137. Paramedic Training Program Approving Authority.
"Paramedic training program approving authority" means an agency or person authorized by this Chapter to approve a Paramedic training program and/or a Critical Care Paramedic (CCP) training program, as follows:
(a) The approving authority for a Paramedic training program and/or a Critical Care Paramedic (CCP) training program conducted by a qualified statewide public safety agency shall be the director of the Authority.
(b) The approving authority for any other Paramedic training program and/or a Critical Care Paramedic (CCP) training program not included in subsection (a) shall be the local EMS agency (LEMSA) which has jurisdiction in the area in which the training program is headquartered.

§ 100138. Paramedic Licensing Authority.
"Paramedic Licensing Authority" means the director of the Authority.

§ 100139. Paramedic.
"Paramedic" or "EMT-P" or "mobile intensive care paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support (ALS); whose scope of practice to provide ALS is in accordance with the standards prescribed by this Chapter, and who has a valid license issued pursuant to this Chapter.

§ 100140. Licensure Skills Examination.
"Skills or practical examination" means the National Registry of Emergency Medical Technicians (NREMT) EMT-Paramedic Practical Examination to test the skills of an individual applying for licensure as a paramedic. Examination results shall be valid for application purposes for two (2) years from the date of examination.
NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code.

§ 100141. Licensure Written Examination.
"Licensure Written Examination" means the NREMT EMT-Paramedic Written Examination to test an individual applying for licensure as a paramedic. Examination results shall be valid for application purposes for two (2) years from date of examination.
NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100142. Local Accreditation.
"Local Accreditation" or "accreditation" or "accreditation to practice" means authorization by the LEMSA to practice as a paramedic within that jurisdiction. Such authorization indicates that the paramedic has completed the requirements of Section 100165 of this Chapter.

§ 100143. State Paramedic Application.
"State Paramedic Application" or "state application" means an application form provided by the Authority to be completed by an individual applying for a license or renewal of license, as identified in Section 100163.

§ 100144. Critical Care Paramedic.
A “Critical Care Paramedic” (CCP) is an individual who is educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed by this Chapter, holds a current certification as a CCP by the Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA.

Article 2. General Provisions

§ 100145. Application of Chapter.
(a) Any LEMSA that authorizes a paramedic training program or an ALS service that provides services utilizing paramedic personnel as part of an organized EMS system, shall be responsible for approving paramedic training programs, paramedic service providers, paramedic base hospitals, and for developing and enforcing standards, regulations, policies and procedures in accordance with this chapter to provide an EMS system quality improvement program, appropriate medical control, and coordination of paramedic personnel and training program(s) within an EMS system.
(b) No person or organization shall offer a paramedic training program, or hold themselves out as offering a paramedic training program, or hold themselves out as providing ALS services utilizing paramedics for the delivery of emergency medical care unless that person or organization is authorized by the LEMSA.
(c) A paramedic who is not licensed in California may temporarily perform his/her scope of practice in California on a mutual aid response, on routine patient transports from out of state into California, or during a special event, when approved by the medical director of the LEMSA, if the following conditions are met:
(1) The paramedic is licensed or certified in another state/country or under the jurisdiction of the federal government.
(2) The paramedic restricts his/her scope of practice to that for which s/he is licensed or certified.
(3) Medical control as specified in Section 1798 of the Health and Safety Code is maintained in accordance with policies and procedures established by the medical director of the LEMSA.
§ 100146. Scope of Practice of Paramedic.
(a) A paramedic may perform any activity identified in the scope of practice of an EMT in Chapter 2 of this Division, or any activity identified in the scope of practice of an Advanced EMT (AEMT) in Chapter 3 of this Division.
(b) A paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this Chapter.
(c) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to Section 1797.195 of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.
(1) Basic Scope of Practice:
   (A) Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).
   (B) Perform defibrillation, synchronized cardioversion, and external cardiac pacing.
   (C) Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with Magill forceps.
   (D) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.
   (E) Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.
   (F) 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.
   (G) Institute intraosseous (IO) needles or catheters.
   (H) Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
   (I) Obtain venous blood samples.
   (J) Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).
   (K) Utilize Valsalva maneuver.
   (L) Perform percutaneous needle cricothyroidotomy.
   (M) Perform needle thoracostomy.
   (N) Perform nasogastric and orogastric tube insertion and suction.
(O) Monitor thoracostomy tubes.
(P) Monitor and adjust IV solutions containing potassium, equal to or less than 40 mEq/L.
(Q) Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.
(R) Administer, using prepackaged products when available, the following medications:
1. 10%, 25% and 50% dextrose;
2. activated charcoal;
3. adenosine;
4. aerosolized or nebulized beta-2 specific bronchodilators;
5. amiodarone;
6. aspirin;
7. atropine sulfate;
8. pralidoxime chloride;
9. calcium chloride;
10. diazepam;
11. diphenhydramine hydrochloride;
12. dopamine hydrochloride;
13. epinephrine;
14. fentanyl;
15. glucagon;
16. ipratropium bromide;
17. lorazepam;
18. midazolam;
19. lidocaine hydrochloride;
20. magnesium sulfate;
21. morphine sulfate;
22. naloxone hydrochloride;
23. nitroglycerin preparations, except IV, unless permitted under (c)(2)(A) of this section;
24. ondansetron;
25. sodium bicarbonate.
(S) In addition to the approved paramedic scope of practice, the CCP may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports, when a licensed and accredited paramedic has completed a Critical Care Paramedic (CCP) training program as specified in Section 100160(b) and successfully completed competency testing, holds a current certification as a CCP from the BCCTPC, and other requirements as determined by the medical director of the LEMSA.
1. set up and maintain thoracic drainage systems;
2. set up and maintain mechanical ventilators;
3. set up and maintain IV fluid delivery pumps and devices;
4. blood and blood products;
5. glycoprotein IIb/IIa inhibitors;
6. heparin IV;
7. nitroglycerin IV;
8. norepinephrine;
9. thrombolytic agents;
10. maintain total parenteral nutrition;

(2) Local Optional Scope of Practice:
(A) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgment of the medical director of the LEMSA, that have been approved by the Director of the Authority when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.
(B) The medical director of the LEMSA shall submit Form #EMSA-0391, Revised 03/18/03 to, and obtain approval from, the Director of the Authority in accordance with Section 1797.172 (b) of the Health and Safety Code for any procedures or medications proposed for use pursuant to this subsection prior to implementation of these medication(s) and or procedure(s).
(C) The Authority shall, within fourteen (14) days of receiving the request, notify the medical director of the LEMSA submitting request Form #EMSA-0391 that the request form has been received, and shall specify what information, if any, is missing.
(D) The Director of the Authority, in consultation with the Emergency Medical Directors Association of California’s Scope of Practice Committee, shall approve or disapprove the request for additional procedures and/or medications and notify the LEMSA medical director of the decision within ninety (90) days of receipt of the completed request. Approval is for a three (3) year period and may be renewed for another three (3) year period, based on evidence from a written request that includes at a minimum the utilization of the procedure(s) or medication(s), beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.
(E) The Director of the Authority, in consultation with a committee of the LEMSA medical directors named by the Emergency Medical Directors Association of California, may suspend or revoke approval of any previously approved additional procedure(s) or medication(s) for cause.

(d) The medical director of the LEMSA may develop policies and procedures or establish standing orders allowing the paramedic to initiate any paramedic activity in the approved scope of practice without voice contact for medical direction from a physician or mobile intensive care nurse (MICN), provided that an EMSQIP, as specified in Chapter 12 of this Division, is in place.


§ 100147. Paramedic Trial Studies.
A paramedic may perform any prehospital emergency medical care treatment procedure(s) or administer any medication(s) on a trial basis when approved by the medical director of the LEMSA and the Director of the Authority.

(a) The medical director of the LEMSA shall review a trial study plan, which at a minimum shall include the following:
(1) A description of the procedure(s) or medication(s) proposed, the medical conditions for which they can be utilized, and the patient population that will benefit.
(2) A compendium of relevant studies and material from the medical literature.
(3) A description of the proposed study design including the scope of the study and method of evaluating the effectiveness of the procedure(s) or medication(s), and expected outcome.
(4) Recommended policies and procedures to be instituted by the LEMSA regarding the use and medical control of the procedure(s) or medication(s) used in the study.
(5) A description of the training and competency testing required to implement the study.

(b) The medical director of the LEMSA shall appoint a local medical advisory committee to assist with the evaluation and approval of trial studies. The membership of the committee shall be determined by the medical director of the LEMSA, but shall include individuals with knowledge and experience in research and the effect of the proposed study on the EMS system.

(c) The medical director of the LEMSA shall submit the proposed study and send a copy of the proposed trial study plan at least forty-five (45) days prior to the proposed initiation of the study to the Director of the Authority for approval in accordance with the provisions of section 1797.172 of the Health & Safety Code. The Authority shall inform the Commission on EMS (Commission) of studies being initiated.

(d) The Authority shall notify, within fourteen (14) days of receiving the request, the medical director of the LEMSA submitting its request for approval of a trial study that the request has been received, and shall specify what information, if any, is missing.

(e) The Director of the Authority shall render the decision to approve or disapprove the trial study within forty-five (45) days of receipt of all materials specified in subsections (a) and (b) of this section.

(f) The medical director of the LEMSA within eighteen (18) months of initiation of the procedure(s) or medication(s), shall submit a written report to the Commission which includes at a minimum the progress of the study, number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(g) The Commission shall review the above report within two (2) meetings and advise the Authority to do one of the following:
(1) Recommend termination of the study if there are adverse effects or no benefit from the study is shown.
(2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential but inconclusive benefit is shown.
(3) Recommend the procedure, or medication, be added to the paramedic basic or local optional scope of practice.
(h) If option (g)(2) is selected, the Commission may advise continuation of the study as structured or alteration of the study to increase the validity of the results.
(i) At the end of the additional eighteen (18) month period, a final report shall be submitted to the Commission with the same format as described in (f) above.
(j) The Commission shall review the final report and advise the Authority to do one of the following:
(1) Recommend termination or further extension of the study.
(2) Recommend the procedure or medication be added to the paramedic basic or local optional scope of practice.
(k) The Authority may require the trial study(ies) to cease after thirty-six (36) months.


§ 100148. Responsibility of the LEMSA.
The LEMSA that authorizes an ALS program shall establish policies and procedures approved by the medical director of the LEMSA that shall include:
(a) Approval, denial, revocation of approval, suspension, and monitoring of training programs, base hospitals or alternative base stations, and paramedic service providers.
(b) Assurance of compliance with provisions of this Chapter by the paramedic program and the EMS system.
(c) Submission to the Authority, as changes occur, of the following information on the approved paramedic training programs:
(1) Name of program director and/or program contact;
(2) Address, phone number, and facsimile number;
(3) Date of approval, date classes will initially begin, and date of expiration.
(d) Development or approval, implementation and enforcement of policies for medical control, medical accountability, and an EMSQIP of the paramedic services, including:
(1) Treatment and triage protocols.
(2) Patient care record and reporting requirements.
(3) Medical care audit system.
(4) Role and responsibility of the base hospital and paramedic service provider.
(e) System data collection and evaluation.


Article 3. Program Requirements for Paramedic Training Programs

§ 100149. Approved Training Programs.
(a) An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in Section 100149(i) of this Chapter, may provide
CCP training upon approval by the paramedic training program approving authority. The purpose of a paramedic training program shall be:

1. To prepare individuals to render prehospital ALS within an organized EMS system;
2. To prepare individuals to render critical care transport within an organized EMS system

By January 1, 2004, all paramedic training programs approved by a paramedic training program approving authority prior to January 1, 2000, shall be accredited and maintain current accreditation by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in order to continue to operate as an approved paramedic training program.

All paramedic training programs approved by a paramedic training program approving authority January 1, 2000, or thereafter shall submit their application, fee, and self study to CoAEMSP for accreditation within twelve (12) months of the start up of classes and receive and maintain CAAHEP accreditation no later than two (2) years from the date of application to CoAEMSP for accreditation in order to continue to operate as an approved paramedic training program.

Paramedic training programs approved according to the provisions of this Chapter shall provide the following information to all their paramedic training program applicants prior to the applicants’ enrollment in the paramedic training program:

1. The date by which the paramedic training program must submit their application and self study for initial accreditation or their application for accreditation renewal to CoAEMSP.
2. The date by which the paramedic training program must be initially accredited or have their accreditation renewed by CAAHEP.
3. Failure of the paramedic training program to submit their application and self study or their accreditation renewal to CoAEMSP by the date specified will result in closure of the paramedic training program by their respective paramedic training program approving authority, unless the paramedic training program approving authority has approved a plan for meeting compliance as provided in Section 100157 of this Chapter. When a paramedic training program approval is revoked under this provision, the paramedic training program course director must demonstrate to the satisfaction of their respective paramedic training program approving authority that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.
4. Failure of the paramedic training program to obtain or maintain CAAHEP accreditation by the required date will result in closure of the paramedic training program by their respective paramedic training program approving authority, unless the paramedic training program approving authority has approved a plan for meeting compliance as provided in Section 100157 of this Chapter. When a paramedic training program approval has been revoked under this provision, the paramedic training...
program course director must demonstrate to the satisfaction of their respective paramedic training program approving authority that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.

(5) Students graduating from a paramedic training program that fails to apply for accreditation with, receive accreditation from, or maintain accreditation with, CAAHEP by the dates required will not be eligible for state licensure as a paramedic.

(e) Paramedic training programs shall submit to their respective paramedic training program approving authority all documents submitted to, and received from, CoAEMSP and CAAHEP for accreditation, including but not limited to, the initial application and self study for accreditation and the documents required for maintaining accreditation.

(f) Paramedic training programs shall submit to the Authority the date their initial application was submitted to CoAEMSP and copies of documentation from CoAEMSP and/or CAAHEP verifying accreditation.

(g) Paramedic training program approving authorities shall revoke approval, in accordance with Section 100157 of this Chapter, of any paramedic training program which fails to comply with subsections (b) through (e) of this Section.

(h) Approved paramedic training programs shall participate in the EMSQIP of their respective paramedic training program approving authority. In addition, an approved paramedic training program, which is conducting a paramedic training program outside the jurisdiction of their approving authority, shall also agree to participate in the EMSQIP of the LEMSA which has jurisdiction where the paramedic training program is being conducted.

(i) Eligibility for program approval shall be limited to the following institutions:

(1) Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary Education.

(2) Medical training units of a branch of the Armed Forces or Coast Guard of the United States.

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5;

(B) Provide continuing education (CE) to other health care professionals; and

(C) are accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

(4) Agencies of government.


§ 100150. Teaching Staff.

(a) Each training program shall have an approved program medical director who shall be a physician currently licensed in the State of California, who has two (2) years
experience in prehospital care in the last five (5) years, and who is qualified by
education or experience in methods of instruction. Duties of the program medical
director shall include, but not be limited to:
(1) Review and approve educational content of the program curriculum, including
training objectives for the clinical and field instruction, to certify its ongoing
appropriateness and medical accuracy.
(2) Review and approve the quality of medical instruction, supervision, and evaluation
of the students in all areas of the program.
(3) Approval of provision for hospital clinical and field internship experiences.
(4) Approval of principal instructor(s).
(b) Each training program shall have an approved course director who shall be licensed
in California as a physician, a registered nurse who has a baccalaureate degree or a
paramedic who has a baccalaureate degree, or shall be an individual who holds a
baccalaureate degree in a related health field or in education. The course director shall
be qualified by education and experience in methods, materials, and evaluation of
instruction, and shall have a minimum of one (1) year experience in an administrative or
management level position and have a minimum of three (3) years academic or clinical
experience in prehospital care education within the last five (5) years. Duties of the
course director shall include, but not be limited to:
(1) Administration, organization and supervision of the educational program.
(2) In coordination with the program medical director, approve the principal instructor,
teaching assistants, field and hospital clinical preceptors, clinical and internship
assignments, and coordinate the development of curriculum, including instructional
objectives, and approve all methods of evaluation.
(3) Ensure training program compliance with this chapter and other related laws.
(4) Sign all course completion records.
(5) Ensure that the preceptor(s) are trained according to the curriculum in subsection
(e)(4).
(c) Each training program shall have a principal instructor(s), who may also be the
program medical director or course director if the qualifications in subsections (a) and
(b) are met, who shall:
(1) Be a physician, registered nurse, physician assistant, or paramedic, currently
certified or licensed in the State of California.
(2) Be knowledgeable in the course content of the United States Department of
Transportation (U.S. DOT) National Emergency Medical Services Education Standards
DOT HS 811 077A, January 2009, herein incorporated by reference; and
(3) Have six years (6) experience in an allied health field and an associate degree or
two (2) years experience in an allied health field and a baccalaureate degree.
(4) Be responsible for areas including, but not limited to, curriculum development,
course coordination, and instruction.
(5) Be qualified by education and experience in methods, materials, and evaluation of
instruction, which shall be documented by at least forty (40) hours of instruction in
teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:

(A) California State Fire Marshal (CSFM) “Training Instructor 1A, 1B, and 1C”,
(B) National Fire Academy (NFA) “Fire Service Instructional Methodology” course, and
(C) A course that meets the U. S. Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the National Association of EMS Educators’ EMS Educator Course.

(d) Each CCP training program shall have a principal instructor(s) who shall be licensed in California as a physician and knowledgeable in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or FP certification from the BCCTPC.

(e) Each training program may have a teaching assistant(s) who shall be an individual(s) qualified by training and experience to assist with teaching of the course. A teaching assistant shall be supervised by a principal instructor, the course director and/or the program medical director.

(f) Each paramedic training program shall have a field preceptor(s) who shall:
   (1) Be a certified or licensed paramedic; and
   (2) Be working in the field as a certified or licensed paramedic for the last two (2) years; and
   (3) Be under the supervision of a principal instructor, the course director and/or the program medical director.

(4) Have completed field preceptor training approved by the LEMSA and/or comply with the field preceptor guidelines approved by the LEMSA. Training shall include a curriculum that will result in the preceptor being competent to evaluate the paramedic student during the internship phase of the training program, and how to do the following in cooperation with the paramedic training program:
   (A) Conduct a daily field evaluation of students.
   (B) Conduct cumulative and final field evaluations of all students.
   (C) Rate students for evaluation using written field criteria.
   (D) Identify ALS contacts and requirements for graduation.
   (E) Identify the importance of documenting student performance.
   (F) Review field preceptor requirements contained in this Chapter.
   (G) Assess student behaviors using cognitive, psychomotor, and affective domains.
   (H) Create a positive and supportive learning environment.
   (I) Measure students against the standard of entry level paramedics.
   (J) Identify appropriate student progress.
   (K) Counsel the student who is not progressing.
   (L) Identify training program support services available to the student and the preceptor.
   (M) Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material.

(g) Each training program shall have a hospital clinical preceptor(s) who shall:
(1) Be a physician, registered nurse or physician assistant currently licensed in the State of California.
(2) Have worked in emergency medical care for the last two (2) years.
(3) Be under the supervision of a principal instructor, the course director, and/or the program medical director.
(4) Receive instruction in evaluating paramedic students in the clinical setting. Means of instruction may include, but need not be limited to, educational brochures, orientation, training programs, or training videos, and shall include how to do the following in cooperation with the paramedic training program:
(A) Evaluate a student’s ability to safely administer medications and perform assessments.
(B) Document a student’s performance.
(C) Review clinical preceptor requirements contained in this Chapter.
(D) Assess student behaviors using cognitive, psychomotor, and affective domains.
(E) Create a positive and supportive learning environment.
(F) Identify appropriate student progress.
(G) Counsel the student who is not progressing.
(H) Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material.


§ 100151. Didactic and Skills Laboratory.
An approved paramedic training program and/or CCP training program shall assure that no more than six (6) students are assigned to one instructor/teaching assistant during skills practice/laboratory.


§ 100152. Hospital Clinical Education and Training for Paramedic.
(a) An approved paramedic training program shall provide for and monitor a supervised clinical experience at a hospital(s) that is licensed as a general acute care hospital and holds a permit to operate a basic or comprehensive emergency medical service. The clinical setting may be expanded to include areas commensurate with the skills experience needed. Such settings may include surgicenters, clinics, jails or any other areas deemed appropriate by the LEMSA. The maximum number of hours in the expanded clinical setting shall not exceed forty (40) hours of the total clinical hours specified in Section 100159(a)(2).
(b) Hospital clinical training, for an approved CCP training program, should consist of no less than ninety-four hours (94) in the following areas:
1) Labor & Delivery (8 hours),
2) Neonatal Intensive Care (16 hours),
(3) Pediatric Intensive Care (16 hours),
(4) Adult Cardiac Care (16 hours),
(5) Adult Intensive Care (24 hours),
(6) Adult Respiratory Care (6 hours), and
(7) Emergency/ Trauma Care (8 hours).
(c) An approved paramedic training program and/or CCP training program shall not enroll any more students than the training program can commit to providing a clinical internship to begin no later than thirty (30) days after a student’s completion of the didactic and skills instruction portion of the training program. The paramedic training program course director and/or CCP training program course director and a student may mutually agree to a later date for the clinical internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student’s military duty, etc.).
(d) Training programs, both paramedic and CCP, in nonhospital institutions shall enter into a written agreement(s) with a licensed general acute care hospital(s) that holds a permit to operate a basic or comprehensive emergency medical service for the purpose of providing this supervised clinical experience.
(e) Paramedic clinical training hospital(s) and other expanded settings shall provide clinical experience, supervised by a clinical preceptor(s). The clinical preceptor may assign the student to another health professional for selected clinical experience. No more than two (2) students shall be assigned to one preceptor or health professional during the supervised clinical experience at any one time. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities, which may include the administration of any additional medications, approved by the LEMSA medical director and the director of the Authority, to result in competency. Clinical assignments shall include, but are not to be limited to, emergency, cardiac, surgical, obstetric, and pediatric patients.

§ 100153. Field Internship.
(a) A field internship shall provide emergency medical care experience supervised at all times by an authorized field preceptor to result in the paramedic student being competent to provide the medical procedures, techniques, and medications specified in Section 100146, in the prehospital emergency setting within an organized EMS system.
(b) An approved paramedic training program shall enter into a written agreement with a paramedic service provider(s) to provide for field internship, as well as for a field preceptor(s) to directly supervise, instruct, and evaluate the students. The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency. If the paramedic service provider is located outside the jurisdiction of the paramedic training program approving authority, then the training program shall do the following:
(1) in collaboration with the LEMSA in which the field internship will occur, ensure that the student has been oriented to that LEMSA, including local policies and procedures and treatment protocols,

(2) contact the LEMSA where the paramedic service provider is located and report to that LEMSA the name of the paramedic intern in their jurisdiction, the name of the EMS provider, and the name of the preceptor. The paramedic intern shall be under the medical control of the medical director of the LEMSA in which the internship occurs.

(c) The training program shall be responsible for ensuring that the field preceptor has the experience and training as required in Section 100150(g)(1)-(4).

(d) The paramedic training program shall not enroll any more students than the training program can commit to providing a field internship to begin no later than ninety (90) days after a student’s completion of the hospital clinical education and training portion of the training program. The training program director and a student may mutually agree to a later date for the field internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student’s military duty, etc.).

(e) For at least half of the ALS patient contacts specified in Section 100159(b), the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through release of the patient to a receiving hospital or medical care facility.

(f) All interns shall be continuously monitored by the training program, in collaboration with the assigned field preceptor, regardless of the location of the internship, as described in written agreements between the training program and the internship provider. The training program shall document a student’s progress, based on the assigned field preceptor’s input, and identify specific weaknesses of the student, if any, and/or problems encountered by, or with, the student. Documentation of the student’s progress, including any identified weaknesses or problems, shall be provided to the student at least twice during the student’s field internship.

(g) No more than one (1) EMT trainee, of any level, shall be assigned to a response vehicle at any one time during the paramedic student’s field internship.


(a) Eligible training institutions shall submit a written request for training program approval to the paramedic training program approving authority. A paramedic training program approving authority may deem a training program approved that has been accredited by the CAAHEP upon submission of proof of such accreditation, without requiring the paramedic training program to submit for review the information required in subsections (b) and (c) of this section.

(b) The paramedic training program approving authority shall receive and review the following prior to program approval:
(1) A statement verifying that the course content meets the requirements contain in the U. S. DOT National Education Standards DOT HS 811 077A January 2009.
(2) A statement verifying that the CCP training program course content meets the requirements contained in Section 100160(b) of this Chapter. The CCP training program must also verify compliance with Subsections (b)(3)-(b)(6) and (b)(8)-(b)(9) of this Section.
(3) An outline of course objectives.
(4) Performance objectives for each skill.
(5) The name and qualifications of the training program course director, program medical director, and principal instructors.
(6) Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
(7) Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
(8) The location at which the courses are to be offered and their proposed dates.
(9) Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.
(10) Written contracts or agreements between the paramedic training program and a provider agency(ies) for student placement for field internship training.
(c) The paramedic training program approving authority shall review the following prior to program approval:
(1) Samples of written and skills examinations administered by the training program for periodic testing.
(2) A final written examination administered by the training program.
(3) Evidence that the training program provides adequate facilities, equipment, examination security, and student record keeping.
(d) The paramedic training program approving authority shall submit to the Authority an outline of program objectives and eligibility on each training program being proposed for approval in order to allow the Authority to make the determination required by section 1797.173 of the Health and Safety Code. Upon request by the Authority, any or all materials submitted by the training program shall be submitted to the Authority.

§ 100155. Paramedic Training Program Approval.
(a) The paramedic training program approving authority shall, within thirty (30) working days of receiving a request for training program approval, notify the requesting training program that the request has been received, and shall specify what information, if any, is missing.
(b) Paramedic training program approval or disapproval shall be made in writing by the
paramedic training program approving authority to the requesting training program after receipt of all required documentation. This time period shall not exceed three (3) months.
(c) The paramedic training program approving authority shall establish the effective date of program approval in writing upon satisfactory documentation of compliance with all program requirements.
(d) Paramedic training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years subject to the procedure for program approval specified in this chapter.

§ 100156. Program Review and Reporting.
(a) All program materials specified in this Chapter shall be subject to periodic review by the paramedic training program approving authority and may also be reviewed upon request by the Authority.
(b) All programs shall be subject to periodic on-site evaluation by the paramedic approving authority and may also be evaluated by the Authority.
(c) Any person or agency conducting a training program shall notify the paramedic training program approving authority in writing, in advance when possible, and in all cases within thirty (30) days of any change in course objectives, hours of instruction, course director, program medical director, principal instructor, provisions for hospital clinical experience, or field internship.

§ 100157. Withdrawal of Program Approval.
(a) Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in denial, probation, suspension or revocation of program approval by the paramedic training program approving authority. Notification of noncompliance and action to place on probation, suspend or revoke shall be done as follows:
(1) A paramedic training program approving authority shall notify the approved training program course director in writing, by certified mail, of the provisions of this Chapter with which the paramedic training program is not in compliance.
(2) Within fifteen (15) days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by certified mail, to the paramedic training program approving authority one of the following:
(A) Evidence of compliance with the provisions of this Chapter, or
(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) days from the day of receipt of the notification of noncompliance.
Within fifteen (15) days of receipt of the response from the approved training program, or within thirty (30) days from the mailing date of the noncompliance notification if no response is received from the approved training program, the paramedic training program approving authority shall notify the Authority and the approved training program in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.

If the paramedic training program approving authority decides to suspend or revoke the training program approval, the notification specified in subsection (a)(3) of this section shall include the beginning and ending dates of the probation or suspension and the 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 paramedic training program approving authority’s letter of decision to the Authority and the training program.


§ 100158. Student Eligibility.
(a) To be eligible to enter a paramedic training program an individual shall meet the following requirements:
   (1) Possess a high school diploma or general education equivalent; and
   (2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association’s Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and
   (3) possess a current EMT certificate or NREMT-Basic registration; or
   (4) possess a current AEMT certificate in the State of California; or
   (5) be currently registered as an EMT-Intermediate with the NREMT.
(b) To be eligible to enter a CCP training program an individual shall be currently licensed, and accredited, in California as a paramedic with three (3) years of basic paramedic practice.


§ 100159. Required Course Hours.
(a) The total paramedic training program shall consist of not less than one thousand and ninety (1090) hours. These training hours shall be divided into:
   (1) A minimum of four-hundred and fifty (450) hours of didactic instruction and skills laboratories;
   (2) The hospital clinical training shall consist of no less than one-hundred and sixty (160) hours and the field internship shall consist of no less than four-hundred and eighty (480) hours.
(b) The student shall have a minimum of forty (40) ALS patient contacts during the field internship as specified in Section 100153. An ALS patient contact shall be defined as
the student performance of one or more ALS skills, except cardiac monitoring and CPR, on a patient.
(c) The minimum hours shall not include the following:
(1) Course material designed to teach or test exclusively EMT knowledge or skills including CPR.
(2) Examination for student eligibility.
(3) The teaching of any material not prescribed in section 100160 of this Chapter.
(4) Examination for paramedic licensure.
(d) The total CCP training program shall consist of not less than two-hundred and two (202) hours. These training hours shall be divided into:
(1) A minimum of one-hundred and eight (108) hours of didactic and skills laboratories; and
(2) No less than ninety-four (94) hours of hospital clinical training as prescribed in Section 100152(b) of this Chapter.

§ 100160. Required Course Content.
(a) The content of a paramedic course shall meet the objectives contained in the U. S. Department of Transportation (DOT) National Emergency Medical Services Education Standards, DOT HS 811 077A, January 2009, to result in the paramedic being competent in the paramedic basic scope of practice specified in Section 100146(a) of this Chapter. The DOT HS 811 077A, can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address: http://www.ems.gov/education/nationalstandardandncs.html
(b) The content of the CCP course shall include:
1. Role of interfacility transport paramedic:
   (A) Healthcare system
   (B) Critical care vs. 9-1-1 system
   (C) Integration and cooperation with other health professionals
   (D) Hospital documentation and charts
   (E) Physician orders vs. ALS protocols
2. Medical – legal issues:
   (A) Emergency Medical Treatment and Active Labor Act (EMTALA)
   (B) Health Insurance Portability and Accountability Act (HIPAA)
   (C) Review of California paramedic scope of practice
   (D) Consent issues
   (E) Do Not Resuscitate (DNR) and Physicians Orders for Life-Sustaining Treatment (POLST)
3. Transport Fundamentals, Safety and Survival
   (A) Safety of the work environment
   (B) Transport vehicle integrity checks
   (C) Equipment functionality checks
(D) Transport mode evaluation, indications for critical care transport and policies

(E) Aircraft Fundamentals and Safety

(F) Flight Physiology

(G) Mission safety decisions

(H) Scene Safety and Post-accident duties at a crash site

(I) Patient Packaging for transport

(J) Crew Resource Management (CRM) & Air Medical Resource Management (AMRM)

(K) Use of safety equipment while in transport

(L) Passenger safety procedures (e.g., specialty teams, family, law enforcement, observer)

(M) Hazard observation and correction during transport vehicle operation

(N) Stressors related to transport (e.g., thermal, humidity, noise, vibration, or fatigue related conditions)

(O) Corrective actions for patient stressors related to transport

(P) Operational procedures:

(1) Dispatching and deployment

(2) Recognition of patients who require a higher level of care
   a. What to do if you are not comfortable with a transport/patient.
   b. When a patient’s needs exceed the staffing available on the unit.

(3) Review of specific county policies

(4) Obtaining and receiving reports from sending/receiving facilities

(5) Re-calculating hanging dose prior to accepting patient

(6) Notification to receiving hospital while en route (cell phone)
   a. Patient status
   b. Estimated time of arrival (ETA)

(7) What to do if the patient deteriorates

(8) Diversion issues

(9) Wait and return calls – continuity of care issues

(10) Documentation
    a. Patient consent forms
    b. Physician order sheets
    c. Critical care flow sheets

4 Shock and Multi-system Organ Failure

(A) Pathophysiology of shock

(B) Types of shock

(C) Shock management

(D) Multi-system organ failure
   1. Recognition and management of sepsis
   2. Recognition and management of disseminated intravascular coagulation (DIC)

5. Basic Physiology for Critical Care Transport and Laboratory and Diagnostic Analysis

Laboratory values:
(A) Arterial blood gases
1. The potential hydrogen (pH) scale
2. Bodily regulation of acid-base balance
3. Practical evaluation of arterial blood gas results

(B) Review of the following to include normal and abnormal values and implications
1. Urinalysis
   a. Normal output
   b. Specific gravity
   c. pH range
2. Complete blood count (CBC)
   a. Hematocrit and Hemoglobin (H&H)
   b. Red blood cell (RBC)
   c. White blood cell (WBC) with differential
   d. Platelets
3. Other
   a. Albumin
   b. Alkaline phosphate
   c. Alanine transaminase (ALT)
   d. Aspartate transaminase (AST)
   e. Bilirubin
   f. Calcium
   g. Chloride
   h. Creatine Kinase (CK) (total and fractions)
   i. Creatinine
   j. Glucose
   k. Lactate
   l. Lactic dehydrogenase (LDH)
   m. Lipase
4. Magnesium
5. Phosphate
6. Potassium
7. Procalcitonin
8. Protein, total
9. Prothrombin Time (PT) and Activated Partial Thromboplastin Time (PTT)
10. Sodium
11. Troponin
12. Urea nitrogen

(C) Practical application of laboratory values to patient presentations

(D) Use of laboratory devices for point of care testing (eg: ISTAT)

(E) Radiographic Interpretation

(F) Wherever appropriate, the above education should include information regarding radiographic findings, pertinent laboratory and bedside testing, and pharmacological interventions
6. Critical Care Pharmacology and Infusion Therapy

Pharmacology and infusion therapies:

(A) Review of common medications encountered in the critical care environment to include those in the following categories:

1. Analgesics
2. Antianginals
3. Antiarrhythmics
4. Antibiotics
5. Anticoagulants
6. Antiemetics
7. Anti-inflammatory agents
8. Antihypertensives
9. Antiplatelets
10. Antitoxins
11. Benzodiazepines
12. Bronchodilators
13. Glucocorticoids
14. Glycoprotein IIb/IIIa inhibitors
15. Histamine Blockers (1 and 2)
16. Induction agents
17. Neuroleptics
18. Osmotic diuretics
19. Paralytics
20. Proton Pump Inhibitors
21. Sedatives
22. Thrombolytics
23. Total Parenteral Nutrition
24. Vasopressors
25. Volume expanders

(B) Review of drug calculation mathematics

1. IV bolus medication
2. IV infusion rates
   a. By volume
   b. By rate

(C) Detailed instruction (drug action and indications, dosages, IV calculation, adverse reactions, contraindications and precautions) on following medications:

1. IV nitroglycerin (NTG)
2. Heparin
3. Potassium chloride (KCl) infusion
4. Lidocaine

(D) Blood and blood products

1. Blood components and their uses in therapy
2. Administrative procedures
3. Administration of blood products
4. Transfusion reactions – recognition, management

(E) Infusion pumps:
1. Set up and maintain IV fluid and medication delivery pumps and devices
2. Discussion of various pumps that may be encountered
3. Discussion of prevention of “run-away” IV lines while transitioning
4. Practical application of transfer of IV infusions, setting drip rates and troubleshooting

(F) Procedures to be used when re-establishing IV lines
1. Hemodynamic monitoring and invasive lines:
   a. Non-invasive monitoring
      1) Non-invasive blood pressure (NIBP)
      2) Pulse oximetry
      3) Capnography
      4) Heart and bowel sound auscultation
   b. Intraosseous (IO) access and infusion - the student must demonstrate competency in the skill of IO infusion
   c. Central Venous Access
      1) Subclavian - the student must demonstrate competency in the skill of subclavian access.
      2) Internal jugular - the student must demonstrate competency in the skill of internal jugular access.
      3) Femoral approach - the student must demonstrate competency in the skill of femoral access.

6. Respiratory Patient Management
   (A) Pulmonary anatomy and physiology
      1. Upper and lower airway anatomy
      2. Mechanics of ventilation and oxygenation
      3. Gas Exchange
      4. Oxyhemoglobin dissociation
   (B) Detailed assessment of the respiratory patient
      1. Obtaining a relevant history
      2. Physical exam
      3. Breath sounds
      4. Percussion
   (C) Causes, pathophysiology, and stages of respiratory failure
   (D) Assessment and management of patients with respiratory compromise
      1. Respiratory failure
      2. Atelectasis
      3. Pneumonia
      4. Pulmonary embolism
      5. Pneumothorax
      6. Spontaneous pneumothorax
7. Hemothorax
6. Pleural effusion
7. Pulmonary edema
8. Chronic obstructive pulmonary disease
9. Adult respiratory distress syndrome (ARDS)

(E) Differential diagnosis of acute and chronic conditions

(F) Management of patient status using
1. Laboratory values, to include but not limited to,
   a. Blood gas values,
   b. Use of ISTAT
2. Diagnostic equipment
   a. Pulse oximetry,
   b. Capnography
   c. Chest radiography
   d. CO-Oximetry (carbon monoxide measurement)

(G) Application of pharmacologic agents for the respiratory patient

(H) Management of complications during transport of the respiratory patient

7. Advanced Airway and Breathing Management Techniques

(A) Indications for basic and advanced airway management
1. Crash airway assessment and management
2. Deteriorating airway assessment and management

(B) Indications, contraindications, complications, and management for specific airway and breathing interventions
1. Needle Cricothyroidotomy
2. Surgical Cricothyroidotomy - the student must demonstrate competency in the skill of surgical cricothyroidotomy.
3. Tracheostomies
   a. Types of tracheostomies
   b. Tracheostomy care
4. Endotracheal intubation – adult, pediatric, and neonatal
   a. Nasotracheal intubation
   b. Rapid Sequence Intubation (RSI) – the student must demonstrate competency in the skill of RSI.
   c. Perilaryngeal airway devices
      1) Combitube
      2) King Airway
      3) Supraglottic airway devices
      4) Laryngeal mask airway devices
5. Pleural decompression
6. Chest tubes
   a. Set up and maintain thoracic drainage systems
   b. Operation of and troubleshooting
   c. Indications for and positioning of dependent tubing
d. Varieties available
e. Gravity drainage
f. Suction drainage
g. On-going assessments of drainage amount and color

7. Portable ventilators
   a. Principles of ventilator operation
   b. Set-up and maintain mechanical ventilation devices
   c. Procedures for transferring ventilator patients
   d. Complications of ventilator management
   e. Troubleshooting and practical application

C. Perform advanced airway and breathing management techniques
   1. Endotracheal intubation – adult, pediatric, and neonatal
   2. Nasotracheal intubation
   3. Rapid Sequence Intubation (RSI)
   4. Pleural decompression

D. Failed airway management and algorithms

E. Perform alternative airway management techniques
   1. Needle Cricothyroidotomy
   2. Surgical Cricothyroidotomy
   3. Retrograde intubation
   4. Perilaryngeal airway devices
   5. Supraglottic airway devices
   6. Laryngeal mask airway devices

F. Airway management and ventilation monitoring techniques during transport

G. Use of mechanical ventilation

H. Administer pharmacology agent for continued airway management

8. Cardiac Patient Management
   (A) Cardiac Anatomy and Physiology and Pathophysiology
   (B) Detailed Assessment of the Cardiac Patient
   (C) Assessment and Management of patients with cardiac events
      1. Acute coronary syndromes,
      2. Heart failure,
      3. Cardiogenic shock,
      4. Primary arrhythmias,
      5. Hemodynamic instability
      6. Vascular Emergencies
   (D) Invasive monitoring (use, care, and complication management)
      1. Arterial
      2. Central venous pressure (CVP)
   (E) Vascular access devices usage and maintenance
   (F) Dressing and site care
   (G) Management of complications
   (H) Manage patient’s status using
1. laboratory values (e.g., blood gas values, ISTAT)
2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
3. 12-lead EKG interpretation:
   a. Essential 12-lead interpretation
   b. Acquisition and transmission
   c. Acute coronary syndromes
   d. The high acuity patient
   e. Bundle branch block and the imitators of acute coronary syndrome (ACS)
   f. Theory and Use of cardiopulmonary support devices as part of patient management
      1) Ventricular assist devices,
      2) Transvenous pacer,
      3) Intra-aortic balloon pump
   g. Application of Pharmacologic agents in Cardiac Emergencies
   h. Management of complications of cardiac patients
   i. Implanted cardioverter defibrillators:
      1) Eligible populations
      2) Mechanism
      3) Complications and patient management
   j. Cardiac pacemakers
      1) Normal operations, troubleshooting and loss of capture
         a). Implanted devices
         b). Unipolar and bipolar
      2) Temporary pacemakers
      3) Transcutaneous pacing
9. Trauma Patient Management
   (A) Differentiate injury patterns associated with specific mechanisms of injury
   (B) Rate a trauma victim using the Trauma Score, to include but not be limited to glasgow coma score, injury severity score, and revised trauma score
   (C) Identify patients who meet trauma center criteria
   (D) Perform a comprehensive assessment of the trauma patient
   (E) Initiate the critical interventions for the management of the trauma patient
   1. Manage the patient with life-threatening thoracic injuries
      a. Tension pneumothorax,
      b. Pneumothorax,
      c. Hemothorax,
      d. Flail chest,
      e. Cardiac tamponade,
      f. Myocardial rupture
   2. Manage the patient with abdominal injuries
      a. diaphragm,
      b. liver,
      c. spleen
3. Manage the patient with orthopedic injuries (e.g. pelvic, femur, spinal)
4. Manage the patient with neurologic injuries
   a. Subdural,
   b. Epidural,
   c. Increased ICP
(F) Manage patient’s status using
   1. laboratory values (e.g., blood gas values, ISTAT)
   2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
(G) Application of pharmacologic agents for trauma management
(H) Manage trauma patient emergencies and complications
   1. the student must demonstrate competency in the skill of chest tube thoracostomy.
   2. The student must demonstrate competency in the skill of pericardiocentesis,
(I) Administer blood and blood products
(J) Trauma considerations:
   1. Trauma assessment,
   2. Adult thoracic & abdominal trauma,
   3. Vascular trauma,
   4. Musculoskeletal trauma,
   5. Burns,
   6. Ocular trauma,
   7. Maxillofacial trauma,
   8. Penetrating & blunt trauma,
   9. Distributive & hypovolemic shock states,
   10. Trauma Systems & Trauma Scoring, and
10. Neurologic Patient Management
   (A) Perform an assessment of the patient
   (B) Conduct differential diagnosis of patients with coma
   (C) Manage patients with seizures
   (D) Manage patients with cerebral ischemia
   (E) Initiate the critical interventions for the management of a patient with a neurologic emergency
   (F) Provide care for a patient with a neurologic emergency
      1. Trauma neurological emergencies
      2. Medical neurological emergencies
      3. Cerebrovascular Accidents,
      4. Neurological shock states
   (G) Assess a patient using the Glasgow coma scale
   (H) Manage patients with head injuries
   (I) Manage patients with spinal cord injuries
   (J) Manage patient’s status using
      1. laboratory values (e.g., blood gas values, ISTAT)
2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)

(K) Intracranial Pressure monitoring.

(L) Application of pharmacologic agents for neurologic patients

(M). Manage neurologic patient complications

11. Toxic Exposure and Environmental Patient Management

(A) Toxic Exposure Patient

1. Perform a detailed assessment of the patient

2. Decontaminate toxicological patients (e.g., chemical/biological/radiological exposure)

3. Administer poison antidotes

4. Provide care for victims of envenomation
   a. Snake bite,
   b. Scorpion sting,
   c. Spider bite

5. Manage patient’s status using
   a. Laboratory values (e.g., blood gas values, ISTAT)
   b. Diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)

6. Administer pharmacologic agents

7. Manage toxicological patients
   a. Medication overdose,
   b. Chemical/biological/radiological exposure

8. Manage toxicological patient complications

(B) Environmental Patient

1. Perform an assessment of the patient

2. Manage the patient experiencing a cold-related illness
   a. Frostbite,
   b. Hypothermia,
   c. Cold water submersion

3. Manage the patient experiencing a heat-related illness
   a. Heat stroke,
   b. Heat exhaustion,
   c. Heat cramps

4. Manage the patient experiencing a diving-related illness
   a. Decompression sickness,
   b. Arterial gas emboli,
   c. Near drowning

5. Manage the patient experiencing altitude-related illness

6. Manage patient’s status using
   a. Laboratory values (e.g., blood gas values, ISTAT)
   b. Diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)

7. Application for pharmacologic agents for toxic exposure and environmental
patients
8. Treat patient with environmental complications

(C) Toxicology:
1. Toxic exposures,
2. Poisonings,
3. Overdoses,
4. Envenomations,
5. Anaphylactic shock, and
6. Infectious diseases.

12. Obstetrical Patient Management
(A) Perform a detailed assessment of the patient
(B) Assess and Manage fetal distress
(C) Manage obstetrical patients
(D) Assess uterine contraction pattern
(E) Conduct interventions for obstetrical emergencies and complications
1. Pregnancy induced hypertension,
2. Hypertonic or titanic contractions,
3. Cord prolapse,
4. Placental abruption
5. Severe preeclampsia involving hemolysis, elevated liver function, and low platelets (HELLP) syndrome.
(F) Determine if transport can safely be attempted or if delivery should be accomplished at the referring facility
(G) Manage patient’s status using
1. laboratory values (e.g., blood gas values, ISTAT)
2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
(H) Application of pharmacologic agents for obstetrical patient management
(I) Manage emergent delivery and post-partum complications
(J) Special Considerations in Obstetrics (OB)/ Gynecology (GYN) Patients
1. Trauma in pregnancy,
2. Renal disorders,
3. Reproductive system disorders

13. Neonatal and Pediatric Patient Management
(A) Neonatal Patient
1. Perform a detailed assessment of the neonatal patient
   a. Management & delivery of the full-term or pre-term newborn,
   b. Management of the complications of delivery
2. Manage the resuscitation of the neonate, including
   a. Umbilical artery catheterization – the student must demonstrate the skill of umbilical catheterization.
3. Manage patient’s status using diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
4. Application of pharmacologic agents for neonatal patient management
5. Manage neonatal patient complications

(B) Pediatric Patient
1. Perform a detailed assessment of the pediatric patient
2. Manage the pediatric patient experiencing a medical event
   a. Respiratory
   b. Toxicity
   c. Cardiac
   d. Environmental
   e. Gastrointestinal (GI)
   f. Endocrine/Metabolic
   g. Neurological
   h. Infectious processes
3. Manage the pediatric patient experiencing a traumatic event
   a. Single vs. multiple system
   b. Burns
   c. Non-accidental trauma
4. Manage patient’s status using
   a. Laboratory values (e.g., blood gas values, ISTAT)
   b. Diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
   c. Application of pharmacologic agents for pediatric patient management
   d. Treat patient with pediatric complications
5. Considerations for Special needs children.

14. Burn Patient Management
   (A) Perform a detailed assessment of the patient
   (B) Calculate the percentage of total body surface area burned
   (C) Manage fluid replacement therapy
   (D) Manage inhalation injuries in burn injury patients
   (E) Manage patient’s status using
      1. Laboratory values (e.g., blood gas values, ISTAT)
      2. Diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
   (F) Application of pharmacologic agents for burn patient management
   (G) Provide treatment of burn complications - the student must demonstrate competency in the skill of escharotomy.

15. General Medical Patient Management
   (A) Perform an assessment of the patient
   (B) Manage patients experiencing a medical condition
      1. Abdominal aortic aneurysm (AAA),
      2. GI bleed,
      3. Bowel obstruction,
      4. Hyperosmolar Hyperglycemic Non-Ketotic Coma (HHNC)
      5. Septic shock,
6. Neurologic emergencies
7. Hypertensive emergencies,
8. Environmental emergencies,
9. Coagulopathies,
10. Endocrine emergencies,
(C) Use of invasive monitoring for the purpose of clinical management
(D) Manage patient’s status using
   1. laboratory values (e.g., blood gas values, ISTAT)
   2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
(E) Application of pharmacologic agents for general medical patient management
(F) Treat patient with general medical complications
(G). Transport considerations of patients with renal or peritoneal dialysis
(H) Transport of Patients with Infection Diseases:
   1 Pathogens
      a. Human immunodeficiency virus (HIV)
      b. Hepatitis
      c. Vancomycin resistant enterococcus (VRE)
      d. Multiple-antibiotic resistant bacteria (MRSA)
      e. Tuberculosis (TB)
      f. Immunocompromised
      g. Others as appropriate
(I) Transport and Management of Patients with Indwelling tubes
   1. Urinary
      a. Foleys
      b. Suprapubic
   2. Nasogastric (NG)
   3. Percutaneous endoscopic gastric (PEG)
   4. Dobhoff tube


§ 100161. Required Testing.
(a) Approved paramedic and CCP training programs shall include periodic examinations and final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.
(b) Successful performance in the clinical and field setting shall be required prior to course completion.

§ 100162. Course Completion Record.
(a) Approved paramedic training program and/or CCP training program shall issue a tamper resistant course completion record to each person who has successfully completed the paramedic training program and/or CCP training program. The course completion record shall be issued no later than ten (10) working days from the date of the student’s successful completion of the paramedic training program and/or CCP training program.

(b) The course completion record shall contain the following:

(1) The name of the individual.
(2) The date of completion.
(3) The following statement:
   (A) "The individual named on this record has successfully completed an approved paramedic training program", or
   (B) "The individual named on this record has successfully completed an approved Critical Care Paramedic training program
(4) The name of the paramedic training program or CCP training program approving authority, depending on the training program being taught.
(5) The signature of the course director.
(6) The name and location of the training program issuing the record.
(7) The following statement in bold print: "This is not a paramedic license."
(8) For paramedic training, a list of optional scope of practice procedures and/or medications approved pursuant to subsection (c) (2)(A)-(D) of Section 100146 taught in the course.
(9) For CCP training, a list of procedures and medications approved pursuant to subsection (c)(1)(S)(1-10) of Section 100146 taught in the course.


Article 4. Applications and Examinations

§ 100163. Date and Filing of Applications.
(a) The Authority shall notify the applicant within thirty (30) days of receipt of the state application that the application was received and shall specify what information, if any, is missing. The types of applications which may be required to be submitted by the applicant are as follows:

(1) Application for Initial License (California Graduate), Form #L-01, Revised 7/2011, herein incorporated by reference.
(2) Application for Initial License of Out-of-State Candidates who are registered with the National Registry of Emergency Medical Technicians, Form #L-01A, Revised 7/2011, herein incorporated by reference.
(4) Application for Lapsed License Reinstatement:
(A) Lapsed Less than One Year, Form #RLL-01A, Revised 06/2012, herein incorporated by reference.
(B) Lapse of One Year or More, Form #RLL-01B, Revised 06/2012, herein incorporated by reference.
(5) Application for Challenge, Form #C L-01A, Revised 06/2012, herein incorporated by reference.
(6) Applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Applicant Submission Form, BCII 8016 (Rev 06/09), submitted to the California Department of Justice (DOJ), for a state and federal criminal history summary provided by the Department of Justice in accordance with the provisions of section 11105 et seq. of the Penal Code.
(b) Applications for renewal of license shall be postmarked, hand delivered, or otherwise received by the Authority at least thirty (30) calendar days prior to expiration of current license. Applications postmarked, hand delivered or otherwise received by the Authority less than thirty (30) days prior to the expiration date of the current license will not cause the license to lapse but will require the applicant to pay a $50 late fee, as specified in Section 100172(b)(4) of this Chapter.
(c) Eligible out-of-state applicants defined in section 100165(b) and eligible applicants defined in section 100165(c) of this Chapter who have applied to challenge the paramedic licensure process shall be notified by the Authority within forty-five (45) working days of receiving the application. Notification shall advise the applicant that the application has been received, and shall specify what information, if any, is missing.
(d) An application shall be denied without prejudice when an applicant does not complete the application, furnish additional information or documents requested by the Authority or fails to pay any required fees. An applicant shall be deemed to have abandoned an application if the applicant does not complete the requirements for licensure within one (1) year from the date on which the application was filed. An application submitted subsequent to an abandoned application shall be treated as a new application.
(e) A complete state application is a signed application submitted to the Authority that provides the requested information and is accompanied by the appropriate application fee(s). All statements submitted by or on behalf of an applicant shall be made under penalty of perjury.

§ 100164. Written and Skills Examination.
(a) Applicants shall comply with the procedures for examination established by the Authority and the NREMT and shall not violate or breach the security of the examination. Applicants found to have violated the security of the examination or
examination process as specified in section 1798.207 of the Health and Safety Code shall be subject to the penalties specified therein.

(b) Students enrolled in an accredited paramedic training program, or a paramedic training program with a current Letter of Review on file with the NREMT, shall be eligible to take the practical examination specified in Sections 100140 of this chapter upon successful completion of didactic and skills laboratory, and shall be eligible to take the written examination specified in Section 100141 when they have successfully completed the didactic, clinical, and field training and have met all the provisions of the approved paramedic training program.


Article 5. Licensure

§ 100165. Licensure.
(a) In order to be eligible for initial paramedic licensure an individual shall meet the following requirements.
(1) Have a paramedic training program course completion record as specified in Section 100162 of this Chapter or other documented proof of successful completion of an approved paramedic training program within the last two years from the date of application to the Authority for paramedic licensure.
(2) Complete and submit the appropriate state application forms as specified in Section 100163.
(3) Provide documentation of successful completion of the paramedic licensure written and practical examinations specified in sections 100140, 100141, and 100164.
(4) Pay the established fees pursuant to Section 100172.
(b) An individual who possesses a current paramedic registration issued by the NREMT, shall be eligible for licensure when that individual fulfills the requirements of subsection (a)(2) and (4) of this section and successfully completes a field internship as defined in Sections 100153 and 100159(b).
(c) A physician, registered nurse or physician assistant currently licensed shall be eligible for paramedic licensure upon:
(1) providing documentation that their training is equivalent to the DOT HS 811 077A specified in Section 100160;
(2) successfully completing a field internship as defined in Sections 100153(a) and 100159(b); and,
(3) fulfilling the requirements of subsection (a)(2) through (a)(4) of this section.
(d) All documentation submitted in a language other than English shall be accompanied by a translation into English certified by a translator who is in the business of providing certified translations and who shall attest to the accuracy of such translation under penalty of perjury.
(e) The Authority shall issue within forty-five (45) calendar days of receipt of a complete application as specified in Section 100163(e) a wallet-sized license to eligible individuals who apply for a license and successfully complete the licensure requirements.

(f) The effective date of the initial license shall be the day the license is issued. The license shall be valid for two (2) years from the last day of the month in which it was issued.

(g) The paramedic shall be responsible for notifying the EMS Authority of her/his proper and current mailing address and shall notify the Authority in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and paramedic license number.

(h) A paramedic may request a duplicate license if the individual submits a request in writing certifying to the loss or destruction of the original license, or the individual has changed his/her name. If the request for a duplicate card is due to a name change, the request shall also include documentation of the name change. The duplicate license shall bear the same number and date of expiration as the replaced license.

(i) An individual currently licensed as a paramedic by the provision of this section is deemed to be certified as an EMT and an AEMT, except when the paramedic license is under suspension, with no further testing required. If certificates are issued, the expiration date of the EMT or AEMT certification shall be the same expiration date as the paramedic license, unless the individual follows the EMT, or AEMT certification/recertification process as specified in Chapters 2 and 3 of this Division.

(j) An individual currently licensed as a paramedic by the provisions of this section may voluntarily deactivate his/her paramedic license if the individual is not under investigation or disciplinary action by the Authority for violations of Health and Safety Code Section 1798.200. If a paramedic license is voluntarily deactivated, the individual shall not engage in any practice for which a paramedic license is required, shall return his/her paramedic license to the Authority, and shall notify any LEMSA with which he/she is accredited as a paramedic or with which he/she is certified as an EMT-I or AEMT that the paramedic license is no longer valid. Reactivation of the paramedic license shall be done in accordance with the provisions of Section 100167(b) of this Chapter.


§ 100166. Accreditation to Practice.

(a) In order to be accredited an individual shall:

(1) Possess a current California paramedic license.

(2) Apply to the LEMSA for accreditation.

(3) Successfully complete an orientation of the local EMS system as prescribed by the LEMSA which shall include policies and procedures, treatment protocols, radio...
communications, hospital/facility destination policies, and other unique system features. The orientation shall not exceed eight (8) classroom hours, except when additional hours are needed to accomplish subsection (a)(4) of this section, and shall not include any further testing of the paramedic basic scope of practice. Testing shall be limited to local policies and treatment protocols provided in the orientation.

(4) Successfully complete training in any basic and/or local optional scope of practice for which the paramedic has not been trained and tested.

(5) Pay the established local fee pursuant to Section 100172.

(6) In order for an individual to be eligible for accreditation, in the LEMSA’s CCP scope of practice, the individual must obtain and maintain CCP certification from the BCCTPC by July 1, 2015.

(b) If the LEMSA requires a supervised field evaluation as part of the local accreditation process, the field evaluation shall consist of no more than ten (10) ALS patient contacts. The field evaluation shall only be used to determine if the paramedic is knowledgeable to begin functioning under the local policies and procedures.

(1) The paramedic accreditation applicant may practice in the basic scope of practice as a second paramedic until s/he is accredited.

(2) The paramedic accreditation applicant may only perform the local optional scope of practice while in the presence of the field evaluator who is ultimately responsible for patient care.

(c) The LEMSA medical director shall evaluate any candidate who fails to successfully complete the field evaluation and may recommend further evaluation or training as required to ensure the paramedic is competent. If, after several failed remediation attempts, the medical director has reason to believe that the paramedic’s competency to practice is questionable, then the medical director shall notify the Authority.

(d) If the paramedic accreditation applicant does not complete accreditation requirements within thirty (30) calendar days, then the applicant may be required to complete a new application and pay a new fee to begin another thirty (30) day period.

(e) A LEMSA may limit the number of times that a paramedic applies for initial accreditation to no more than three (3) times per year.

(f) The LEMSA shall notify the individual applying for accreditation of the decision whether or not to grant accreditation within thirty (30) calendar days of submission of a complete application.

(g) Accreditation to practice shall be continuous as long as licensure is maintained and the paramedic continues to meet local requirements for updates in local policy, procedure, protocol and local optional scope of practice, and continues to meet requirements of the system-wide EMSQIP pursuant to Section 100168.

(h) An application and fee may only be required once for ongoing accreditation. An application and fee can only be required to renew accreditation when an accreditation has lapsed.

(i) The medical director of the LEMSA may suspend or revoke accreditation if the paramedic does not maintain current licensure or meet local accreditation requirements and the following requirements are met:
(1) The paramedic has been granted due process in accordance with local policies and procedures.
(2) The local policies and procedures provide a process for appeal or reconsideration.
(i) The LEMSA shall submit to the Authority the names and dates of accreditation for those individuals it accredits within twenty (20) working days of accreditation.
(k) During an interfacility transfer, a paramedic may utilize the scope of practice for which s/he is trained and accredited.
(l) During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting LEMSA.

Article 6. License Renewal

§ 100167. License Renewal
(a) In order to be eligible for renewal of a non-lapsed paramedic license, an individual shall comply with the following requirements:
(1) Possess a current paramedic license issued in California.
(2) Complete forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division.
(3) Complete and submit the state Paramedic Application for License Renewal, Form #RL-01, Revised 07/2011 including the Statement of Continuing Education located on the back of the license renewal application. EMSA will notify the paramedic, by mail, approximately six (6) months prior to their paramedic license expiration date on how to renew their license.
(4) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.
(b) In order for an individual whose license has lapsed to be eligible for license renewal, the following requirements shall apply:
(1) For a lapse of less than six (6) months, the individual shall comply with (a)(2), and (a)(4) of this section and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.
(2) For a lapse of six months (6) or more, but less than twelve (12) months, the individual shall comply with (a)(2), and (a)(4) of this section, complete an additional twelve (12) hours of CE, for a total of sixty (60) hours of CE, and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.
(3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall pass the licensure examination specified in Sections 100140,
100141, and 100164 or possess a current paramedic registration issued by the NREMT, comply with (a) (2) and (a)(4) of this section, submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCIII 8016 (Rev 03/07), for a state summary criminal history provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code, complete an additional twenty-four (24) hours of CE, for a total of seventy-two (72) hours of CE and complete and submit a state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.

(4) For a lapse of twenty-four (24) months or more, the individual shall comply with (a)(2) and (a)(4) and (b)(3) of this section. Documentation of the seventy-two (72) hours of CE shall include completion of the following courses, or their equivalent:

(A) Advanced Cardiac Life Support,
(B) Pediatric Advanced Life Support,
(C) Prehospital Trauma Life Support or International Trauma Life Support,
(D) CPR.

(c) Renewal of a license shall be for two (2) years. If the renewal requirements are met within six months (6) prior to the expiration date of the current license, the effective date of licensure shall be the first day after the expiration of the current license. This applies only to individuals who have not had a lapse in licensure.

(d) For individuals whose license has lapsed, the licensure cycle shall be for two (2) years from the last day of the month in which all licensure requirements are completed and the license was issued.

(e) The Authority shall notify the applicant for license renewal within thirty (30) working days of receiving the application that the application has been received and shall specify what information, if any, is missing.

(f) An individual, who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose paramedic license expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, has an additional six (6) months to comply with the CE requirements and the late renewal fee is waived upon compliance with the following provisions:

(1) Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual’s dates of activation and deactivation/release from active duty.

(2) Meet the requirements of Section 100167(a)(2) through (a)(4) of this Chapter, except the individual will not be subject to the $50 late renewal application fee specified in Section 100172(b)(4).

(3) Provide documentation showing that the CE activities submitted for the license renewal period were taken not earlier than 30 days prior to the effective date of the individual’s paramedic license that was valid when the individual was activated for active duty and not later than six (6) months from the date of deactivation/release from active duty.
(A) For an individual whose active duty required him/her to use his/her paramedic skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS Continuing Education Regulations (California Code of Regulations, Title 22, Division 9). The documentation shall include verification from the individual’s Commanding Officer attesting to the classes attended.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185 and 1797.210, Health and Safety Code, and Section 101, Chapter 1, Part 1, Subtitle A, Title 10, United States Code.

Article 7. System Requirements

§ 100168. Paramedic Service Provider.
(a) A LEMSA with an ALS system shall establish policies and procedures for the approval, designation, and evaluation through its EMSQIP, of all paramedic service provider(s).
(b) An approved paramedic service provider shall:
(1) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol personnel, etc.).
(2) Utilize and maintain telecommunications as specified by the LEMSA.
(3) Maintain a drug and solution inventory as specified by the LEMSA of equipment and supplies commensurate with the basic and local optional scope of practice of the paramedic.
(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:
1. controlled substance ordering and order tracking;
2. controlled substance receipt and accountability;
3. controlled substance master supply storage, security and documentation;
4. controlled substance labeling and tracking;
5. vehicle storage and security;
6. usage procedures and documentation;
7. reverse distribution;
8. disposal;
9. re-stocking procedures.
(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to:
10. controlled substance testing;
11. discrepancy reporting;
12. tampering, theft and diversion prevention and detection;
13. usage audits.
(4) Have a written agreement with the LEMSA to participate in the EMS system and to
comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA’s EMSQIP as specified in Chapter 12 of this Division.

(5) Be responsible for assessing the current knowledge of their paramedics in local policies, procedures and protocols and for assessing their paramedics’ skills competency.

(6) If, through the EMSQIP the employer or medical director of the LEMSA determines that a paramedic needs additional training, observation or testing, the employer and the medical director may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the employer and the medical director, the decision of the medical director shall prevail.

(c) No paramedic service provider shall advertise itself as providing paramedic services unless it does, in fact, routinely provide these services on a continuous twenty-four (24) hours per day basis and meets the requirements of subsection (b) of this section.

(d) No responding unit shall advertise itself as providing paramedic services unless it does, in fact, provide these services and meets the requirements of subsection (a) of this section.

(e) The LEMSA may deny, suspend, or revoke the approval of a paramedic service provider for failure to comply with applicable policies, procedures, and regulations.


§ 100169. Paramedic Base Hospital.

(a) A LEMSA with an ALS system shall designate a paramedic base hospital(s) or alternative base station, pursuant to Health and Safety Code Section 1798.105 if no qualified base hospital is available to provide medical direction, to provide medical direction and supervision of paramedic personnel.

(b) A designated paramedic base hospital shall be responsible for the provisions of subsections (b)(1) through (b)(13) of this section, and alternate base stations shall be responsible for the provisions of subsections (b)(4) through (b)(13) of this section.

(1) Be licensed by the California Department of Public Health as a general acute care hospital, or, for an out of state general acute care hospital, meet the relevant requirements for that license and the requirements of this section where applicable, as determined by the LEMSA which is utilizing the hospital in the local EMS system.

(2) Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

(3) Have a special permit for basic or comprehensive emergency medical service pursuant to the provisions of Division 5, or have been granted approval by the Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code. Hospitals meeting requirements in this section shall be referenced in the EMS Plan of the approving LEMSA.
(4) Have and agree to utilize and maintain two-way telecommunications equipment, as specified by the LEMSA, capable of direct two-way voice communication with the paramedic field units assigned to the hospital.

(5) Both parties shall maintain a record of all online medical direction between the service provider and base hospital or alternative base station as specified by LEMSA policy.

(6) Have a written agreement, which is reviewed every three (3) years, with the LEMSA indicating the concurrence of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation as specified in this Chapter and by the LEMSA’s policies and procedures.

(7) Have a physician licensed in the State of California, experienced in emergency medical care, assigned to the emergency department, available at all times to provide immediate medical direction to the MICN or paramedic personnel. This physician shall have experience in and knowledge of base hospital radio operations and LEMSA policies, procedures, and protocols.

(8) Assure that nurses giving medical direction to paramedic personnel are trained and authorized as MICNs by the medical director of the LEMSA.

(9) Designate a paramedic base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the medical director of the LEMSA when the medical director determines that an individual with these qualifications is not available. The base hospital medical director shall be regularly assigned to the emergency department, have experience in and knowledge of base hospital radio operations and LEMSA policies and procedures, and shall be responsible for functions of the base hospital including the EMSQIP.

(10) Identify a base hospital coordinator who is a currently licensed in California registered nurse with experience in and knowledge of base hospital operations and LEMSA policies and procedures. The base hospital coordinator shall serve as a liaison to the local EMS system.

(11) Ensure that a mechanism exists for prehospital providers to contract for the provision of medications, medical supplies and equipment used by paramedics according to policies and procedures established by the LEMSA.

(12) Provide for CE in accordance with the policies and procedures of the LEMSA.

(13) Agree to participate in the LEMSA’s EMSQIP which may include making available all relevant records for program monitoring and evaluation.

(c) The LEMSA may deny, suspend, or revoke the approval of a base hospital or alternative base station for failure to comply with any applicable policies, procedures, and regulations.

§ 100170. Medical Control.
The medical director of the LEMSA shall establish and maintain medical control in the following manner:
(a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:
(1) Treatment protocols that encompass the paramedic scope of practice.
(2) Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA.
(3) Criteria for initiating specified emergency treatments on standing orders or for use in the event of communication failure that is consistent with this Chapter.
(4) Criteria for initiating specified emergency treatments, prior to voice contact, that are consistent with this Chapter.
(5) Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance or when the patient refuses transport.
(6) Requirements for the initiation, completion, review, evaluation, and retention of a patient care record as specified in this Chapter. These requirements shall address but not be limited to:
(A) Initiation of a record for every patient response.
(B) Responsibilities for record completion.
(C) Record distribution to include LEMSA, receiving hospital, paramedic base hospital, alternative base station, and paramedic service provider.
(D) Responsibilities for record review and evaluation.
(E) Responsibilities for record retention.
(b) Establish policies which provide for direct voice communication between a paramedic and a base hospital physician or MICN, as needed.
(c) Retrospectively, by providing for organized evaluation and CE for paramedic personnel. This shall include, but not be limited to:
(1) Review by a base hospital physician or MICN of the appropriateness and adequacy of paramedic procedures initiated and decisions regarding transport.
(2) Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.
(3) Organized field care audit(s).
(4) Organized opportunities for CE including maintenance and proficiency of skills as specified in this Chapter.
(d) In circumstances where use of a base hospital as defined in Section 100169 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the EMS Authority.
Article 8. Record Keeping and Fees.

§ 100171. Record Keeping.
(a) Each paramedic approving authority shall maintain a record of approved training programs within its jurisdiction and annually provide the Authority with the name, address, and course director of each approved program. The Authority shall be notified of any changes in the list of approved training programs.
(b) Each paramedic approving authority shall maintain a list of current paramedic program medical directors, course directors, and principal instructors within its jurisdiction.
(c) The Authority shall maintain a record of approved training programs.
(d) Each LEMSA shall, at a minimum, maintain a list of all paramedics accredited by them in the preceding five (5) years.
(e) The paramedic is responsible for accurately completing the patient care record referenced in Section 100170(a)(6) which shall contain, but not be limited to, the following information when such information is available to the paramedic:
   (1) The date and estimated time of incident.
   (2) The time of receipt of the call (available through dispatch records).
   (3) The time of dispatch to the scene.
   (4) The time of arrival at the scene.
   (5) The location of the incident.
   (6) The patient's:
      (A) Name;
      (B) Age;
      (C) Gender;
      (D) Weight, if necessary for treatment;
      (E) Address;
      (F) Chief complaint; and
      (G) Vital signs.
   (7) Appropriate physical assessment.
   (8) The emergency care rendered and the patient's response to such treatment.
   (9) Patient disposition.
   (10) The time of departure from scene.
   (11) The time of arrival at receiving facility (if transported).
   (12) The name of receiving facility (if transported).
   (13) The name(s) and unique identifier number(s) of the paramedics.
   (14) Signature(s) of the paramedic(s).
(f) A LEMSA utilizing computer or other electronic means of collecting and storing the information specified in subsection (e) of this section shall in consultation with EMS providers establish policies for the collection, utilization and storage of such data.
§ 100172. Fees.
(a) A LEMSA may establish a schedule of fees for paramedic training program review and approval, CE provider approval, and paramedic accreditation in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.
(b) The following are the licensing fees established by the Authority:
(1) The fee for initial application for paramedic licensure for individuals who have completed training in California through an approved paramedic training program shall be $50.00.
(2) The fee for initial application for paramedic licensure for individuals who have completed out-of-state paramedic training, as specified in Section 100165(b), or for individuals specified in Section 100165(c), shall be $100.00.
(3) The fee for licensure or licensure renewal as a paramedic shall be $195.00.
(4) The fee for failing to submit an application for renewal within the timeframe specified in Section 100163(b), or for an individual whose license has lapsed, as specified in Section 100167(b)(1), (2), (3) and (4) shall be $50.00.
(5) The fee for state summary criminal history shall be in accordance with the schedule of fees established by the California DOJ.
(6) The fee for replacement of a license shall be $10.00.
(7) The fee for approval and re-approval of an out-of-state CE provider shall be $200.00.
(8) The fee for administration of the provisions of Section 17520 of the Family Code shall be $5.00.


Article 9. Discipline and Reinstatement of License

§ 100173. Proceedings.
(a) Any proceedings by the Authority to deny, suspend or revoke the license of a paramedic or place any paramedic license holder on probation pursuant to Section 1798.200 of the Health and Safety Code, or impose an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, shall be conducted in accordance with this article and pursuant to the provisions of the Administrative Procedure Act, Government Code, Section 11500 et seq.
(b) Before any disciplinary proceedings are undertaken, the Authority shall evaluate all information submitted to or discovered by the Authority including, but not limited to, a recommendation for suspension or revocation from a medical director of a LEMSA, for evidence of a threat to public health and safety pursuant to Section 1798.200 of the Health and Safety Code.
The Authority shall use the “EMS Authority Recommended Guidelines for Disciplinary Orders and Conditions of Probation”, dated July 26, 2008 and incorporated by reference herein, as the standard in settling disciplinary matters when a paramedic applicant or license holder is found to be in violation of Section 1798.200 of Division 2.5 of the Health and Safety Code.

The administrative law judge shall use the “EMS Authority Recommended Guidelines for Disciplinary Orders and Conditions of Probation”, dated July 26, 2008, as a guide in making any recommendations to the Authority for discipline of a paramedic applicant or license holder found in violation of Section 1798.200 of Division 2.5 of the Health and Safety Code.


§ 100174. Denial/Revocation Standards.
(a) The Authority shall deny/revoke a paramedic license if any of the following apply to the applicant:
   (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 (2) or more felonies.
   (4) Is on parole or probation for any felony.
(b) The Authority shall deny/revoke a paramedic license, if any of the following apply to the applicant:
   (1) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.
   (2) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.
   (3) Has been convicted of two (2) misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
   (4) Has been convicted of two (2) misdemeanors within the preceding five (5) years for any offense relating to force, violence, threat, or intimidation.
   (5) Has been convicted within the preceding five (5) years of any theft related misdemeanor.
(c) The Authority may deny/revoke a paramedic license if any of the following apply to the applicant:
   (1) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.
   (2) Is required to register pursuant to Section 11590 of the Health & Safety Code.
(d) Subsections (a) and (b) shall not apply to convictions that have been pardoned by the governor, and shall only apply to convictions where the applicant/licensee was
prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (a) and (b). As used in this section, “felony” or “offense punishable as a felony” refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

(e) This section shall not apply to those paramedics who obtained their California Paramedic License prior to the effective date of this Section; unless:

(1) The licensee is convicted of any misdemeanor or felony subsequent to the effective date of this Section.

(2) The licensee committed any sexually related offense specified under Section 290 of the Penal Code.

(3) The licensee failed to disclose to the Authority any prior convictions when completing his/her application for initial paramedic license or license renewal.

(f) Nothing in this section shall prevent the Authority from taking licensure action pursuant to Health & Safety Code Section 1798.200.

(g) The Director of the Authority may grant a license to anyone otherwise precluded under subsections (a) and (b) of this section if the Director of the Authority believes that extraordinary circumstances exist to warrant such an exemption.

(h) Nothing in this section shall negate an individual's right to appeal the denial of a license or petition for reinstatement of a license pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.


§ 100175. Substantial Relationship Criteria for the Denial, Placement on Probation, Suspension, Fine, or Revocation of a License.

(a) For the purposes of denial, placement on probation, suspension, or revocation, of a license, pursuant to Section 1798.200 of the Health and Safety Code, or imposing an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, a crime or act shall be substantially related to the qualifications, functions and/or duties of a person holding a paramedic license under Division 2.5 of the Health and Safety Code. A crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a paramedic if to a substantial degree it evidences present or potential unfitness of a paramedic to perform the functions authorized by her/his license in a manner consistent with the public health and safety.

(b) For the purposes of a crime, the record of conviction or a certified copy of the record shall be conclusive evidence of such conviction. "Conviction" means the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere.

§ 100176. Rehabilitation Criteria for Denial, Placement on Probation, Suspension, Revocations, and Reinstatement of License.

(a) At the discretion of the Authority, the Authority may issue a license subject to specific provisional terms, conditions, and review. When considering the denial, placement on probation, suspension, or revocation of a license pursuant to Section 1798.200 of the Health and Safety Code, or a petition for reinstatement or reduction of penalty under Section 11522 of the Government Code, the Authority in evaluating the rehabilitation of the applicant and present eligibility for a license, shall consider the following criteria:

(1) The nature and severity of the act(s) or crime(s).
(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial, placement on probation, suspension, or revocation which also could be considered grounds for denial, placement on probation, suspension, or revocation under Section 1798.200 of the Health and Safety Code.
(3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subsection (1) or (2) of this section.
(4) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the person.
(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.
(6) Evidence, if any, of rehabilitation submitted by the person.

SUBJECT: S-SV EMS AGENCY POLICY ACTIONS

PURPOSE

To provide a mechanism for development of a new policy/protocol, and revision or deletion of an existing policy/protocol (hereinafter referred to as "Policy Action").

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.107, 1797.171, 1797.172, 1797.176, 1797.202, 1797.220 and 1798

California Code of Regulations, Title 22

POLICY

Consideration will be given to suggestions/requests from S-SV EMS system participants for the development of new policies/protocols or the revision of existing policies/protocols.

All policy actions shall be placed on the S-SV EMS Agency Regional Medical Control Committee (MCC) meeting agenda for two meetings, at minimum, before final action is taken.

No EMS service provider shall develop or institute a patient care policy/protocol that conflicts with any S-SV EMS Agency policy/protocol. This does not apply to EMS Aircraft treatment protocols developed by individual providers for their RN or other higher level of care personnel.

PROCEDURE

A. Proposed policy actions will be drafted by the S-SV EMS Agency.

1. Input may be solicited from appropriate individuals, agencies, organizations and/or S-SV EMS Agency regional advisory committees.

2. The S-SV EMS Agency may establish an ad hoc task force, as necessary, to discuss selected policy actions.

3. The "draft" will be reviewed and revised by the Agency, as often as necessary, throughout the process.
B. Approval process of policy actions will occur as follows:

1. Proposed policy actions ("draft" policies) will be placed on the agenda of the S-SV Regional Medical Control Committee (MCC).
   a. The proposed policy actions will be reviewed and discussed. No final action will be taken the first time the "draft" policy is placed on the meeting agenda.
   b. S-SV will incorporate recommendation(s) of the MCC into the "draft" and place the revised "draft" policy on the MCC agenda as a "Final Review and Approval" agenda item.
   c. At minimum, a proposed policy action will be placed on the MCC meeting agenda for two meetings. If further recommendations are received, the proposed policy action will be placed on the agenda, as necessary, until a consensus is reached by the committee.
   d. Recommendation(s) of the advisory S-SV Regional Medical Control Committee will be taken under consideration by the S-SV Medical Director.

2. Routine review of existing S-SV EMS Agency Policies/Protocols:
   a. Each existing S-SV EMS Agency policy/protocol should be reviewed at least every three years.
   b. Policies/protocols may be reviewed on a more frequent basis if necessary due to regulatory, standard of care, or other changes.
   c. The process indicated above will be used for the routine review of existing policies/protocols.

C. Implementation of Policy Actions will occur as follows:

1. New policies/protocols will be assigned an S-SV EMS policy/protocol number.

2. An effective date and next review date will be assigned to all policies/protocols.

3. The Regional Executive Director and the S-SV EMS Medical Director will sign the policy/protocol.

4. Appropriate parties will be notified of the action:
SUBJECT: S-SV EMS AGENCY POLICY ACTIONS

a. Policy/protocol updates are normally scheduled for release on a bi-annual basis for June 1st and December 1st implementation.

b. Policy/protocol updates may be released more frequently if necessary due to unique circumstances.

D. Some Policy Actions may require immediate action to maintain compliance with state regulation or law, or to preserve medical control and/or system integrity (see Crisis Standard of Care Procedures, Reference No. 838). Policy Actions of this type may be implemented by the S-SV EMS Agency as urgency measures, and scheduled for discussion at the next regularly scheduled MCC advisory meeting.

CROSS REFERENCES:

Policy and Procedure Manual

Crisis Standard of Care Procedures, Reference No. 838
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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY
REFERENCE NO. 305

SUBJECT: BASE/MODIFIED BASE HOSPITAL PROGRAM

PURPOSE:
To establish the requirements and standards for base/modified base hospital medical direction and supervision of Advanced EMT (AEMT) and paramedic personnel in the S-SV EMS region.

AUTHORITY:
California Health and Safety Code, Division 2.5, Sections 1797.16, 1797.107, 1797.171, 1797.204, 1797.206, 1797.214, 1797.218, 1797.220, 1798.102, and 1798.104

California Code of Regulations, Title 22, Division 9:
• Chapter 3, Section 100127 (AEMT)
• Chapter 4, Section 100169 (Paramedic)

DEFINITIONS:

Base Hospital – A hospital that meets the requirements of this policy and utilizes S-SV EMS Agency authorized Mobile Intensive Care Nurses (MICNs) and/or emergency department physicians (‘Base Hospital Physicians’) to provide medical direction and supervision to AEMT and paramedic personnel in the S-SV EMS Region. Base hospitals shall have a current Base Hospital Agreement in place with the S-SV EMS Agency in order to operate as such.

Modified Base Hospital – A hospital that meets the requirements of this policy and utilizes only emergency department physicians (‘Modified Base Hospital Physicians’) to provide medical direction and supervision to AEMT and paramedic personnel in the S-SV EMS Region. Modified base hospitals shall have a current Modified Base Hospital Agreement in place with the S-SV EMS Agency in order to operate as such.

Emergency Medical Services Quality Improvement Program (EMSQIP) – Methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct process, and recognize excellence in performance and delivery of care, pursuant to the provisions of California Code of Regulations, Title 22, Chapter 12 and the S-SV EMS Agency ‘Continuous Quality Improvement Program (CQIP)’ policy, Reference No. 620.

Effective Date: 06/01/2013
Next Review Date: 04/2016
Approved:

SIGNATURE ON FILE
S-SV EMS Medical Director

SIGNATURE ON FILE
S-SV EMS Regional Executive Director

Date last Reviewed/Revised: 04/13
Page 1 of 6
SUBJECT: BASE/MODIFIED BASE HOSPITAL PROGRAM

POLICY:

The S-SV EMS Agency shall designate base/modified hospitals to provide medical direction and supervision to AEMT and paramedic prehospital personnel in the S-SV EMS region.

PROCEDURE:

A. Advanced EMT (AEMT) Base/Modified Base Hospital

1. A designated AEMT Base/Modified base hospital shall:

   a. Be licensed by the California Department of Public Health Services as a general acute care hospital.

   b. Have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of California Code of Regulations, Title 22, Division 5, or have been granted approval by the California EMS Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code.

   c. Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

   d. Have and agree to utilize and maintain two-way telecommunications as specified by the S-SV EMS Agency, capable of direct two-way voice communication with AEMT field units and personnel.

   e. Both parties shall maintain a record of all online medical direction between the service provider and the base/modified base hospital as specified by S-SV EMS Agency policy.

   f. Have a written agreement, which is reviewed every three (3) years, with the S-SV EMS Agency indicating the concurrence of hospital administration, medical staff and emergency department staff to meet the requirements for program participation as specified in this policy.

   g. Assure that a physician, licensed in California, experienced in emergency medical care, assigned to the emergency department, is available at all times to provide immediate medical direction to MICN or AEMT personnel. This physician shall have experience in and knowledge of base/modified base hospital radio operations and S-SV EMS Agency policies, procedures and protocols.

   h. Assure that the nurses giving radio direction to AEMT personnel are trained and authorized as MICNs by the S-SV EMS Agency.
i. Designate an AEMT base/modified base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the S-SV EMS Agency Medical Director. This physician shall be regularly assigned to the emergency department, have experience in and knowledge of base/modified base hospital telecommunications and S-SV EMS Agency policies, procedures and protocols, and shall be responsible for functions of the base/modified base hospital including the EMSQIP.

j. Identify a base/modified base hospital coordinator who is a California licensed Registered Nurse with experience in and knowledge of base/modified base hospital operations and S-SV EMS Agency policies, procedures and protocols to act as a prehospital liaison to the local EMS system.

k. Ensure that a mechanism exists for prehospital providers to contract for the provision of medications, medical supplies and equipment used by AEMT personnel according to policies and procedures established by the S-SV EMS Agency.

l. Provide for CE in accordance with the policies and procedures of the S-SV EMS Agency.

m. Agree to participate in the S-SV EMS Agency EMSQIP, which may include making available all relevant records for program monitoring and evaluation.

2. A paramedic base/modified base hospital may serve as an AEMT base/modified base hospital.

3. The S-SV EMS Agency may deny, suspend, or revoke the approval of a base/modified base hospital for failure to comply with any applicable policies, procedures, and regulations.

B. Paramedic Base/Modified Base Hospital

1. A designated Paramedic Base/Modified Base hospital shall:

   a. Be licensed by the California Department of Public Health as a general acute care hospital, or, for an out of state general acute care hospital, meet the relevant requirements for that license and the requirements of this section where applicable, as determined by the S-SV EMS Agency.

   b. Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

   c. Have a special permit for basic or comprehensive emergency medical service pursuant to the provisions of California Code of Regulations, Title 22,
Division 5, or have been granted approval by the California EMS Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code.

d. Have and agree to utilize and maintain two-way telecommunications equipment, as specified by the S-SV EMS Agency, capable of direct two-way voice communication with paramedic field units and personnel.

e. Both parties shall maintain a record of all online medical direction between the service provider and the base/modified base hospital as specified by S-SV EMS Agency policy.

f. Have a written agreement, which is reviewed every three (3) years, with the S-SV EMS Agency indicating the concurrence of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation as specified in this policy.

g. Have a physician licensed in the State of California, experienced in emergency medical care, assigned to the emergency department; available at all times to provide immediate medical direction to MICN or paramedic personnel. This physician shall have experience in and knowledge of base/modified base hospital radio operations and S-SV EMS Agency policies, procedures and protocols.

h. Assure that nurses giving medical direction to paramedic personnel are trained and authorized as MICNs by the S-SV EMS Agency.

i. Designate a paramedic base/modified base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the S-SV EMS Agency Medical Director. The base/modified base hospital medical director shall be regularly assigned to the emergency department, have experience in and knowledge of base/modified base hospital radio operations and S-SV EMS Agency policies, procedures and protocols, and shall be responsible for functions of the base/modified base hospital including the EMSQIP.

j. Identify a base hospital coordinator who is a California licensed registered nurse with experience in and knowledge of base/modified base hospital operations and S-SV EMS Agency policies, procedures and protocols. The base/modified base hospital coordinator shall serve as a liaison to the local EMS system.

k. Ensure that a mechanism exists for prehospital providers to contract for the provision of medications, medical supplies and equipment used by paramedics according to policies and procedures established by the S-SV EMS Agency.
1. Provide for CE in accordance with the policies and procedures of the S-SV EMS Agency.

m. Agree to participate in the S-SV EMS Agency EMSQIP which may include making available all relevant records for program monitoring and evaluation.

n. The S-SV EMS Agency may deny, suspend, or revoke the approval of a base/modified base hospital for failure to comply with any applicable policies, procedures and regulations.

GENERAL PROVISIONS

A. Education:

An S-SV EMS Agency approved base/modified base hospital shall:

1. Act as an education resource for prehospital provider agencies.

2. Maintain approval as an EMS continuing education (CE) provider.

3. Provide formal education programs (including lectures/seminars, call critiques, etc.) for prehospital personnel.

4. Assist in providing special and mandatory training programs deemed necessary by the S-SV EMS Agency. This shall include education/training regarding new medications and procedures.

5. Provide supervised clinical experience for prehospital care students/trainees in accordance with California Code of Regulations, Title 22 and S-SV EMS Agency policies and procedures.

6. Provide clinical remediation of skills training for prehospital personnel as needed.

B. EMS System Involvement:

An S-SV EMS Agency approved base/modified base hospital shall participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.

C. Patient Care Records:

An S-SV EMS Agency approved base/modified base hospital shall participate in a collaborative manner with S-SV EMS Agency data collection programs.
D. Multi Casualty Incidents/Disaster Planning and Response:

1. An S-SV EMS Agency approved base/modified base hospital shall reasonably participate in local and regional disaster drills; including utilization of the S-SV EMS Agency approved regional electronic hospital alerting and assessment system (e.g., EMResource™).

2. An S-SV EMS Agency approved base/modified base hospital shall actively participate in local and regional disaster related planning efforts.

3. During a Multi Casualty Incident (MCI) or disaster, the procedures indicated in the applicable OES Region III/OES Region IV MCI Plans and S-SV EMS Agency policies shall be followed.

CROSS REFERENCES:

Prehospital Care Policy Manual

Recording Voice Communication and Maintenance of Records, Reference No. 306

Prehospital Documentation, Reference No. 605

Continuous Quality Improvement Program (CQIP), Reference No. 620

Base/Modified Base/Receiving Hospital Contact, Reference No. 812

Multi Casualty Incidents (MCI), Reference No. 837

Crisis Standard of Care Procedures, Reference No. 838

Infrequently Used Skills - Verification of Maintenance/Regional Training Module, Reference No. 1110
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<td>477</td>
<td>EMT Optional Skill: Service Provider Application, Approval Process, Requirements and Responsibilities</td>
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SIERRA-SACRAMENTO VALLEY EMS AGENCY

PROVIDER AGENCIES
SECTION IV

SUBJECT: INDEX REFERENCE NO. 400

477-A  EMT Optional Skill - Service Provider Application Form
477-B  EMT Optional Skill - Status Report Form
477-C  EMT Optional Skill - Skills Check Documentation Record
SUBJECT: AEMT & PARAMEDIC SERVICE PROVIDER RESPONSIBILITIES

PURPOSE:

To establish the requirements for all S-SV EMS Agency approved Advanced EMT (AEMT) and/or paramedic prehospital service provider agencies.

AUTHORITY:

California Health and Safety Code, Division 2.5

California Code of Regulations, Title 22, Division 9, Chapters 3 & 4

POLICY:

A. AEMT Prehospital Service Provider Agency Specific Responsibilities:

1. An approved AEMT prehospital service provider agency shall:

   a. Provide emergency medical service response on a continuous twenty-four (24) hours per day basis unless otherwise specified by the S-SV EMS Agency, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol, personnel, etc.).

   b. Have and agree to utilize and maintain telecommunications as specified in S-SV EMS Agency policies.

   c. Maintain LALS medical equipment and supplies specified in S-SV EMS Agency policies.

   d. Ensure that security mechanisms and procedures are established for controlled substances, when applicable, as indicated in S-SV EMS Agency policies.

   e. Have a written agreement with the S-SV EMS Agency to participate in the EMS system and to comply with all applicable State regulations, and local policies and procedures, including participation in the S-SV EMS Agency Emergency Medical Services Quality Improvement Program (EMSQIP).
SUBJECT: AEMT & PARAMEDIC SERVICE PROVIDER RESPONSIBILITIES

f. Be responsible for assessing the current knowledge of their AEMTs in local policies, procedures, and protocols and for assessing their AEMTs skills competency.

2. If, through the EMSQIP the employer or S-SV EMS Agency Medical Director determines that an AEMT needs additional training, observation or testing, the employer and the S-SV EMS Agency Medical Director may create a specific and targeted program of remediation based upon the identified need of the AEMT. If there is disagreement between the employer and the S-SV EMS Agency Medical Director, the decision of the S-SV EMS Agency Medical Director shall prevail.

3. No AEMT service provider shall advertise itself as providing LALS or ALS services unless it does, in fact, routinely provide LALS or ALS services on a continuous twenty-four (24) hours per day basis, and meets the requirements of S-SV EMS Agency policies.

4. No responding unit shall advertise itself as providing LALS or ALS services unless it does, in fact, provide LALS or ALS services and meets the requirements of S-SV EMS Agency policies.

5. The S-SV EMS Agency may deny, suspend, or revoke the approval of an AEMT service provider for failure to comply with applicable policies, procedures, and regulations.

B. Paramedic Prehospital Service Provider Agency Specific Responsibilities:

1. An approved paramedic prehospital service provider agency shall:

   a. Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the S-SV EMS Agency, in which case there shall be an adequate justification for the exemption (e.g., lifeguards, ski patrol personnel, etc.).

   b. Utilize and maintain telecommunications as specified in S-SV EMS Agency policies.

   c. Maintain ALS medical equipment and supplies specified in S-SV EMS Agency policies.

   d. Ensure that security mechanisms and procedures are established for controlled substances as indicated in S-SV EMS Agency policies.

   e. Have a written agreement with the S-SV EMS Agency to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the S-SV EMS Agency Emergency Medical Services Quality Improvement Program (EMSQIP).
SUBJECT: AEMT & PARAMEDIC SERVICE PROVIDER RESPONSIBILITIES

f. Be responsible for assessing the current knowledge of their paramedics in local policies, procedures and protocols and for assessing their paramedics’ skills competency.

2. If, through the EMSQIP the employer or S-SV EMS Agency Medical Director determines that a paramedic needs additional training, observation or testing, the employer and the S-SV EMS Agency Medical Director may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the employer and the S-SV EMS Agency Medical Director, the decision of the S-SV EMS Agency Medical Director shall prevail.

3. No paramedic prehospital service provider shall advertise itself as providing paramedic services unless it does, in fact, routinely provide these services on a continuous twenty-four (24) hours per day basis and meets the requirements of S-SV EMS Agency policies.

4. No responding unit shall advertise itself as providing paramedic services unless it does, in fact, provide these services and meets the requirements of S-SV EMS Agency policies.

5. The S-SV EMS Agency may deny, suspend, or revoke the approval of a paramedic prehospital service provider agency for failure to comply with applicable policies, procedures, and regulations.

C. General AEMT and/or Paramedic Prehospital Service Provider Agency Responsibilities:

1. Education:

An S-SV EMS Agency approved AEMT and/or paramedic prehospital service provider agency shall:

a. Maintain approval as an EMS continuing education (CE) provider.

b. Provide formal education programs (including lectures/seminars, call critiques, etc.) for prehospital personnel.

c. Provide special and mandatory training programs deemed necessary by the S-SV EMS Agency. This shall include education/training regarding new medications and procedures.

d. Provide supervised field internship experience for prehospital care students/trainees in accordance with California Code of Regulations, Title 22 and S-SV EMS Agency policies and procedures.

e. Provide remediation of skills training for prehospital personnel as needed.
2. EMS System Involvement:

An S-SV EMS Agency approved AEMT and/or paramedic prehospital service provider agency shall participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.

3. Patient Care Records:

An S-SV EMS Agency approved AEMT and/or paramedic prehospital service provider shall participate in a collaborative manner with S-SV EMS Agency data collection programs.

4. Multi Casualty Incidents/Disaster Planning and Response:

An S-SV EMS Agency approved AEMT and/or paramedic prehospital service provider agency shall:

a. Reasonably participate in regional and local MCI and disaster drills.

b. Actively participate in regional and local disaster related planning efforts.

c. Follow the procedures indicated in the applicable OES Region III/OES Region IV MCI Plans and S-SV EMS Agency policies during a Multi Casualty Incident (MCI) or disaster.

CROSS REFERENCES:

Policy and Procedure Manual

Service Provider Application Process & Procedure, Reference No. 410

Prehospital Documentation, Reference No. 605

Continuous Quality Improvement Program, Reference No. 620

Prehospital Provider Agency Inventory Requirements, Reference No. 701

Management of Controlled Substances, Reference No. 710

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

Multi Casualty Incidents (MCI), Reference No. 837

Crisis Standard of Care Procedures, Reference No. 838
SUBJECT: AEMT & PARAMEDIC SERVICE PROVIDER RESPONSIBILITIES

EMS Incident Reporting & Investigation, Reference No. 927

Infrequently Used Skills: Verification of Maintenance/Regional Training Module, Reference No. 1110
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Policy
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PURPOSE:

To establish the minimum requirements for emergency ambulance dispatch in the S-SV EMS region. It is the intention of this policy to provide individuals in need of emergency prehospital medical assistance with qualified prehospital care in the most expeditious manner possible.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797 et seq.
California Code of Regulations, Title 22, Division 9.

DEFINITIONS:

Exclusive Operating Area (EOA) – An EMS area or sub area defined by the emergency medical services plan for which the S-SV EMS Agency restricts operations to one provider of emergency (911) ground ambulance services

PSAP – Public Safety Answering Point – The designated primary public safety agency at which the 911 call is first received

Secondary PSAP – Secondary Public Safety Answering Point – A dispatch center that the PSAP transfers/relays the emergency calls to for the purpose of dispatching emergency resources, including ambulances
Ambulance Provider Dispatch Center – An S-SV EMS Agency approved 911 ambulance provider dispatch center that the PSAP or Secondary PSAP transfers/relays the emergency calls to for the purpose of dispatching ambulance resources

EMD – Emergency Medical Dispatch – A series of components approved by the S-SV EMS Agency that allows the dispatcher to provide pre-arrival instructions and, if utilized, dispatch an appropriate level of response as determined by the approved EMD protocols (Priority Dispatch)

Ambulance Response Modes – Two accepted modes of responding to requests for emergency medical assistance which are defined as follows:

A. Code Two (2) response – A response mode without the use of emergency warning lights and/or sirens

B. Code Three (3) response – An emergency response using red lights and sirens (CVC section 21055 & CCR 1105 &1107.7)

S-SV EMS Agency Approved 911 Ambulance Provider – An ambulance service provider who has a current 911 Exclusive Operating Agreement (EOA) with the S-SV EMS Agency or a provider currently authorized by the S-SV EMS Agency to provided 911 ambulance services in a non EOA area

POLICY:

A. Any S-SV EMS Agency approved provider dispatch center (including approved, non 911 ambulance providers), PSAP and/or Secondary PSAP receiving a request for emergency medical assistance, either through the 911 system or via a seven digit number, from any member of the public shall promptly notify the appropriate communications center for the first responder and/or the appropriately 911 ambulance provider of the call.

B. All S-SV EMS Agency approved 911 ambulance providers shall operate their own dispatch center, contract with an existing dispatch center, or join with other providers to operate a dispatch system. If a 911 ambulance provider utilizes dispatch services provided by another organization, it must have a written contract for that service.

C. All S-SV EMS Agency approved 911 ambulance providers shall provide dispatch services necessary to receive and respond to requests for emergency ambulance services and monitor system status. The 911 ambulance provider’s dispatch center shall:

   1. Receive and process calls for emergency medical assistance from primary and secondary 911 PSAPs and seven digit telephone lines
2. Identify and dispatch the closest available S-SV EMS Agency approved 911 ambulance to the scene of the emergency in accordance with the EOA requirements listed below in section D

3. Only dispatch the number of ambulances appropriate for the type of incident or as requested by the IC

4. Notify responding personnel and agencies of pertinent information

5. Monitor and track responding resources (Automatic Vehicle Locators are recommended)

6. Coordinate with law enforcement, first responders and other EMS providers as needed

7. Provide required data and reports to the S-SV EMS Agency

D. To maintain the integrity of all EOA’s within the S-SV EMS Region, the exclusive provider for the service area where the call is located shall be dispatched to all emergency calls within that service area unless a closer provider is requested through mutual aid or through a previously agreed upon automatic aid agreement.

E. It is the goal of the S-SV EMS Agency that all callers requesting emergency medical assistance from any area or jurisdiction within the S-SV EMS Region have direct access to qualified emergency medical dispatch (EMD) personnel for the provision of emergency dispatch services, pre-arrival instructions and post dispatch instructions. National certification of the dispatch center’s program is encouraged, but not required.

F. If the dispatch agency utilizes an S-SV EMS Agency approved priority dispatch system, the dispatcher shall follow the protocols associated with that system.

G. Provider ambulances shall not at any time proceed at a level of response other than as directed by the Primary PSAP, Secondary PSAP or ambulance provider dispatcher.

H. 911 ambulance providers shall have a written policy and shall make all reasonable efforts to immediately notify the jurisdictional PSAP of the location from where the ambulance is responding from.

I. The dispatch center shall be staffed with sufficient properly trained personnel to accomplish all dispatch and EMD functions (if provided).

J. A computer-aided dispatch (CAD) system shall be utilized to record dispatch information for all ambulance requests. CAD system shall include the date, hours, minutes and seconds.
K. The dispatch center shall have capabilities for 24-hour, “real time” recordings of all emergency telephone lines and radio frequencies. All radio and telephone communications shall be recorded on tape or other digital recording medium and kept for a minimum of 90 days.

L. Ambulance providers shall have a plan to provide emergency ambulance dispatch during any period of primary dispatch failure. The plan shall ensure that an equivalent dispatch center or dispatch system, approved by the S-SV EMS Agency, is able to serve as a backup dispatch center within five (5) minutes of failure of the primary dispatch center.

CROSS REFERENCES:

Prehospital Care Policy Manual

Emergency Medical Dispatch Program Approval, Reference No. 405

911 Ambulance Response Time Criteria, Reference No. 415
SUBJECT: 911 AMBULANCE RESPONSE TIME CRITERIA

PURPOSE:

To establish response time standards and reporting criteria for all transporting 911 Advanced Life Support (ALS) ambulance providers.

In order to establish a policy on response time it is necessary to standardize the definition of response time. It is our purpose to establish fully automated response time reporting within the S-SV region.

AUTHORITY:

California Health & Safety Code, Division 2.5, Sections 1797 et seq.

California Code of Regulations, Title 22, Division 9.

California Vehicle Code, Division 11, Section 21055.

California Code of Regulations, Title 13, Division 2, Chapter 5, Article 1, Sections 1100.7. and 1105.

California EMS Authority, EMS System Standards and Guidelines, Section 4.06.

DEFINITIONS:

Ambulance Response Time Zone - A geographic area, with boundaries established by the S-SV EMS Agency.

Code 3 – An emergency response using red lights and siren - (CVC section 21055 & CCR 1107.7 & 1105).

Dispatch Time – The point in time when a 911 ALS ambulance unit has been notified of a request for 911 ALS ambulance service.

On Scene Time - The point in time when the 9-1-1 ALS ambulance unit arrives at the address site or at a designated or assigned staging area.

Provider Dispatch Center - A dispatch center that the PSAP or Secondary PSAP transfers/relays the emergency calls to for the purpose of dispatching resources.
**Provider Dispatch Notification Time** – The point in time when the provider dispatch is notified of the 911 call or the emergency.

**PSAP – Public Safety Answering Point** – The designated primary public safety agency or secondary PSAP at which the 911 call is first received and/or transferred.

**PSAP Notification Time** – The point in time when a 911 call is received by the PSAP.

**Response Time** – The time calculated from “Response Time Clock Start” to “On Scene Time”.

**Response Time Clock Start** – The point in time at which the response time clock starts for each individual 911 ambulance provider. See Policy section, item C.

**Response Time Compliance Report** – Report submitted monthly to S-SV EMS Agency by all transporting 911 ALS ambulance providers detailing compliance to the response time standards in this policy.

**Secondary PSAP – Secondary Public Safety Answering Point** – A dispatch center that the PSAP transfers/relays the emergency calls to for the purpose of dispatching resources.

**Secondary PSAP Notification Time** – The point in time when the secondary PSAP is notified of the 911 call or the emergency.

**POLICY**

A. **Response Areas Population Density** – When establishing response times the following shall be taken into consideration:

1. Call Volume
2. Population density
3. Type of event

B. 911 ALS ambulance providers shall ensure that an ALS ambulance is on scene of all Code-3 calls 90% of the time as measured within the geographic service areas defined in the addendums for the counties as listed below:

1. Placer County – Addendum A
2. Yolo County – Addendum B
3. Sutter and Yuba County – Addendum C
4. Nevada County – Addendum D
5. Colusa County – Addendum E
6. Butte County – Addendum F
C. For all 911 or 7 digit access calls dispatched code 3 the Response Time Clock Start and End Times are indicated below:

**American Medical Response – Placer County**

- **PSAP** → **Secondary PSAP** (in some cases) → **AMR Dispatch Center** → **AMR Ambulance Unit** → **On Scene**

**Bi-County Ambulance**

- **PSAP** → **Bi-County Dispatch Center** → **Bi-County Ambulance Unit** → **On Scene**

**Foresthill Fire Protection District**

- **PSAP** → **Foresthill Fire Ambulance Unit** → **On Scene**

**Sierra Nevada Ambulance**

- **PSAP** → **Secondary PSAP** → **Sierra Nevada Ambulance Unit** → **On Scene**

**Penn Valley Fire District**

- **PSAP** → **Secondary PSAP** → **Penn Valley Ambulance Unit** → **On Scene**
South Placer Fire Protection District

PSAP → South Placer Fire Ambulance Unit → On Scene

North Tahoe Fire Protection District

PSAP → Secondary PSAP → North Tahoe Fire Ambulance Unit → On Scene

Truckee Fire Protection District

PSAP → Secondary PSAP → Truckee Fire Ambulance Unit → On Scene

Enloe EMS – Colusa County

PSAP → Enloe Dispatch Center → On Scene

Butte County EMS

PSAP → Butte County EMS Dispatch Center → On Scene
D. Actual response time shall be computed to the second with no rounding of numbers.

E. In calculating compliance with response time requirements, calls dispatched other than Code-3 shall be excluded. This includes cancelled enroute or calls downgraded from Code 3 to Code 2. Calls located outside of a provider’s exclusive operating area shall not be included in response time calculations.

F. The calculation of the ninety (90%) requirement shall be made on a monthly basis.

G. During periods of system overload, ALS overhead personnel who are a routine part of the EMS delivery system (Field Supervisors, Battalion Chiefs, etc.) may be used in the calculation of the 911 ambulance response time if previously approved by the Agency and the following criteria are met:

1. Personnel are employed by/working for the 911 ambulance provider and are licensed and accredited as a paramedic in the S-SV EMS region.

2. Response vehicles used by these personnel are fully equipped according to S-SV EMS Policy #701 for ALS Non-Transport and are inspected and approved by the Agency.

In these circumstances, the On Scene time of the ALS overhead personnel may be used in calculating the total 911 ambulance response time. The response time shall be calculated from the “Response Time Clock Start” as listed above under item C, until the first ALS overhead personnel arrives on scene. These times may be utilized in the overall monthly response time calculations. Each instance where these alternate times are used must be separately identified in the monthly response time compliance report and shall include the following information:

a. Total response time for the initial ALS overhead personnel.

b. Total response time for the transport ambulance.

c. Any additional pertinent information (cancelled call, ambulance reduced to code 2, RAS / AMA, etc.).

H. Responses delayed by events beyond the control of ambulance provider (e.g., adverse weather conditions, freeway gridlock, road construction, train crossing, etc.) have been considered in determining the response time standards and shall not be considered as automatic exceptions to the response time standard.

Official declared disasters may be considered by the Agency as reason to temporarily adjust response time standards. In addition, it is recognized that extreme weather can affect response times, i.e. snow with chain control. Providers experiencing these issues shall notify the Agency and request an exemption.
I. In the event that response time compliance for single or multiple zones with a call volume of less than 50 calls in that calendar month fall below 90%, the provider may exclude one (1) late call from each low volume zone that falls below 90% compliance for that month for the purpose of response time calculation. All of the following criteria must be met for the provider to utilize this exemption:

1. Provider must exclude the entire call for purposes of calculating the response compliance for that zone (i.e. excluded from both the total call tally as well as the late call tally).

2. Provider must clearly identify the call(s) that they are excluding, the total response time for the excluded call(s), and the reason why the excluded call(s) were late in their monthly report.

3. Provider may utilize this exemption for no more than three (3) consecutive months or a total of four (4) months in any twelve (12) consecutive month period for a particular low volume response zone.

J. The provider is responsible for maintaining official response times for the Agency in a secure manner that prevents the changing of any information without such a change being permanently recorded.

K. Every ambulance service shall submit the following information to the S-SV EMS Agency data system:

1. Response Time Clock Start Time for all 911 calls or 7 digit access calls dispatched code 3.

2. On scene time.

L. 911 ambulance providers shall submit a monthly response time compliance report for all code 3 calls, utilizing CAD data, to the S-SV EMS Agency.
<table>
<thead>
<tr>
<th>RESPONSE TIME STANDARDS</th>
<th>PLACER COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMERICAN MEDICAL RESPONSE (AMR)</strong></td>
<td></td>
</tr>
<tr>
<td>Roseville</td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td>Rocklin</td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Auburn City &amp; County</strong></td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td>All of the City of Auburn and County area – ½ mile West of Hwy 49 from the City of Auburn to Dry Creek Road. East of Hwy 49 up to and including Interstate 80 North to include Bell Road. In addition, ½ mile East of Hwy 49 from Bell Road to Dry Creek Road.</td>
<td></td>
</tr>
<tr>
<td><strong>Auburn – East to include Colfax</strong></td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Auburn West to Rocklin</strong></td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Lincoln</strong></td>
<td>10 Minutes 90% of the time</td>
</tr>
<tr>
<td><strong>AMR Placer County Rural</strong></td>
<td>20 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>AMR Placer County - Wilderness</strong></td>
<td>As soon as possible</td>
</tr>
<tr>
<td><strong>SOUTH PLACER FIRE PROTECTION DISTRICT</strong></td>
<td></td>
</tr>
<tr>
<td>South Placer FPD</td>
<td>ALS on scene 10 minutes 90% of the time and ambulance on scene 15 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>FORESTHILL FIRE PROTECTION DISTRICT</strong></td>
<td></td>
</tr>
<tr>
<td>Foresthill, Todd Valley Estates, Baker Ranch</td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Foresthill - Wilderness</strong></td>
<td>As soon as possible</td>
</tr>
<tr>
<td><strong>NORTH TAHOE FIRE PROTECTION DISTRICT</strong></td>
<td></td>
</tr>
<tr>
<td>Kings Beach and Tahoe City</td>
<td>10 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Remainder of NTFPD</strong></td>
<td>20 minutes 90% of the time</td>
</tr>
<tr>
<td><strong>Wilderness</strong></td>
<td>As soon as possible</td>
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REMOVE
Policy
415-B
Effective
7-1-2013
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SUBJECT: 9-1-1 RESPONSE TIME CRITERIA – NEVADA COUNTY

RESPONSE TIME STANDARDS

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<tr>
<th>SIERRA NEVADA MEMORIAL HOSPITAL AMBULANCE</th>
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<tr>
<td>Grass Valley and Nevada City</td>
<td>9 minutes 90% of the time</td>
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<tr>
<td>Sierra Nevada Rural 15:</td>
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<td>Nevada County Consolidated Fire District, Ophir Hill FPD, Highway 49 through Higgins FPD to include the corridor ½ mile east and west of Hwy 49, and Lake of the Pines.</td>
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<tr>
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<td>Those portions of Higgins FPD not contained in the 15 min response zone. Peardale-Chicago Park FPD.</td>
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<tr>
<td>Penn Valley Rural</td>
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REMOVE
Policy Addendums
415-E & 415-F
SUBJECT: TACTICAL MEDICINE OPERATIONAL PROGRAMS

PURPOSE:

To define the approval, training, utilization, and equipment requirements of tactical medicine operational programs in the S-SV EMS region.

DEFINITION:

Tactical Medicine – The delivery of medical services for law enforcement special operations.

AUTHORITY:

California Health and Safety Code 1797.218, 1797.220 and 1798

California Code of Regulations, Title 22, Division 9, Section 100145 & 100169

California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations – July 2009

OVERVIEW:

The tactical incident response environment presents unique challenges to law enforcement personnel and for the personnel providing emergency medical care and support services in that environment. Tactical medical care providers must have a clear understanding of and consideration for law enforcement response and tactics and the mission-specific objectives of a tactical operation when planning for and providing medical support. The primary goal of tactical medicine is to support and assist a tactical team in accomplishing its mission during a deployment or response to a critical incident.

INDICATIONS:

Approved tactical medical personnel should be utilized when appropriate and available to provide medical support services for law enforcement special operations.
SUBJECT: TACTICAL MEDICINE OPERATIONAL PROGRAMS

PROCEDURE:

A. Tactical medicine programs shall be developed and utilized in accordance with the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document which can be located on the EMSA website at http://www.emsa.ca.gov/personnel/files/TacticalMedicine.pdf.

B. Tactical medicine programs shall be reviewed and approved by the S-SV EMS Agency.

C. Designated Tactical Emergency Medical Support (TEMS) personnel shall successfully complete all initial and ongoing recommended training provided by an approved tactical medicine training program as listed in the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document.

D. Equipment and supplies carried and utilized by Tactical Emergency Medical Support (TEMS) personnel shall be consistent with the items listed in the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document. Equipment and supplies shall be based on the appropriate level and approved scope of practice of personnel utilized for the particular tactical medicine program (TEMS BLS or TEMS ALS).
SUBJECT: AUTO AID/MUTUAL AID/OUT-OF-REGION RESPONSE

PURPOSE:

To provide guidelines pertaining to when and under what conditions an EMR, EMT, AEMT or Paramedic certified/licensed/accredited in California may legally function in their respective classification during transport, auto aid, mutual aid and disaster responses. This includes day-to-day auto aid/mutual aid responses as well as officially requested Fireline Paramedic Program and Ambulance Strike Team activations.

AUTHORITY:

California Health and Safety Code, Section 1797.170(b), 1797.204 & 1797.220

California Code of Regulations, Title 22, Division 9

- Chapter 2 (EMT), §100061, §100062(c), §100064(a) (f) and (l)
- Chapter 3 (AEMT), §100126(a)
- Chapter 4 (Paramedic), §100142, §100144(c), §100145(b), §100165(a) and (l)

California Disaster and Civil Defense Master Mutual Aid Agreement, November 1950

California EMS Authority ‘Ambulance Strike Team/Medical Task Forces (AST) Guidelines’ #215, July 2003

California EMS Authority Mutual Aid White Paper ‘Compendium of Statutes and Regulations Related to EMT and Paramedic Scope of Practice During Mutual Aid in California’, December 2011

California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, February 2012

Emergency Management Assistance Compact (EMAC)

Supplemental Interstate Compact For Emergency Mutual Assistance, July 2007
DEFINITIONS:

Ambulance Strike Team – A group of five (5) ambulances of the same type with common communications and a leader. The strike teams may be all ALS or all BLS.

Auto Aid – Agreements between two or more jurisdictions where the nearest available resource is dispatched to an emergency irrespective of jurisdictional boundaries or where two or more agencies are automatically dispatched simultaneously to predetermined types of emergencies. This type of mutual aid agreement is typically utilized on a day-to-day basis.

Disaster Assistance - Similar to mutual aid but are requests for assistance in the event that a disaster overwhelms local resources. These requests may be under existing mutual aid agreements or the result of unforeseen needs arising from a particularly large-scale disaster.

Fireline Paramedic: A paramedic who meets all pre-requisites established by Firescope and is authorized by their department to provide ALS treatment on the fireline.

Medical Task Force – Any combination of resources assembled to support a specific medical mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.

Mutual Aid – Agreements between two or more jurisdictions to provide assistance across jurisdictional boundaries, when requested, as a result of the circumstances of an emergency exceeding local resources.

PRINCIPLES:

A. When requested by an officially recognized auto aid/mutual aid/disaster assistance requester, EMS personnel may utilize the scope of practice for which they are trained and certified/licensed/accredited according to the California Code of Regulations and the policies and procedures established by the S-SV EMS Agency.

B. These guidelines are not intended to replace existing EMS or circumvent the established response of EMS in the local County or EMS region.

PROCEDURE:

A. All Auto Aid, Mutual Aid and Out-Of-Region Responses

1. EMS personnel shall follow all S-SV EMS policies and treatment protocols in the provision of prehospital emergency care and shall not administer any medication or perform any procedures listed as ‘Base/Modified Base Hospital
Physician Order Only’ without such approval from an S-SV EMS Base/Modified Base Hospital Physician.

2. Controlled substances will be obtained, secured and inventoried as indicated in S-SV EMS ‘Management of Controlled Substances’ policy, Reference No. 710.

3. Documentation of patient care will be completed as indicated in S-SV EMS ‘Prehospital Documentation’ policy, Reference No. 605.

4. Prehospital QI will be completed as indicated in S-SV EMS ‘Continuous Quality Improvement Program (CQIP) policy, Reference No. 620.

B. Fireline Paramedic Programs Additional Requirements

1. Fireline Paramedic programs shall be reviewed and approved by the S-SV EMS Agency.

2. Designation by the Paramedic’s S-SV EMS Agency approved ALS Provider Agency as a Fireline Paramedic ensures that the Paramedic has completed standard Firescope education.

3. The Fireline Paramedic shall present their credentials (Paramedic license, S-SV EMS Agency accreditation card and department identification) to the Medical Unit Leader upon arrival at the incident.

4. S-SV EMS Agency approved Fireline Paramedic personnel shall carry the items listed in S-SV EMS Agency ‘Fireline Paramedic Inventory’ policy, Reference No. 702, when responding to wildland fires to provide ALS care in such a capacity.

C. Ambulance Strike Team Additional Requirements

S-SV EMS Agency approved ambulance service provider agencies shall have a fully executed ‘California Ambulance Providers’ Agreement for Participation in State Requested Ambulance Strike Team and Medical Task Force Deployments’ Memorandum of Understanding (MOU) in place with the California EMS Authority in order to participate in an ambulance strike team/medical task force request.

POLICY:

A. EMR

A S-SV EMS Agency certified EMR may utilize their EMR Scope of Practice in a volunteer or paid capacity and for any provider. There is no requirement for an EMR to be affiliated with a provider.
B. EMT

1. A California certified EMT is recognized as an EMT statewide regardless of where in California they are certified.

2. EMTs may utilize their EMT Scope of Practice in a volunteer or paid capacity and for any provider. There is no requirement for an EMT to be affiliated with a provider.

3. During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which he/she is trained, certified and accredited according to the policies and procedures established by his/her certifying or accrediting LEMSA.

C. AEMT

California AEMTs may practice anywhere in California provided all of the following conditions are met:

1. They are in possession of a valid California AEMT Certificate

2. They are accredited by a LEMSA

3. They are affiliated with an LALS or ALS provider that is approved by the LEMSA with whom they are accredited

4. They may utilize the scope of practice as defined by the LEMSA with whom they are accredited

D. PARAMEDIC

California Paramedics may practice anywhere in California provided all of the following conditions are met:

1. They are in possession of a valid California Paramedic License

2. They are accredited by a LEMSA

3. They are affiliated with an ALS provider that is approved by the LEMSA with whom they are accredited

4. They may utilize the scope of practice for which he/she is trained and accredited according to the policies and procedures established by his/her accrediting LEMSA
E. Out-of-State Response

For officially requested auto aid/mutual aid/disaster responses outside of California, EMS personnel are normally approved to utilize the scope of practice for which he/she is trained and certified/licensed/accredited according to their respective classification. However, EMS personnel should check in with the Medical Unit Leader or other appropriate representative of the incident for any special restrictions or temporary credentialing requirements.

CROSS REFERENCES:

Prehospital Care Policy Manual

Prehospital Documentation, Reference No. 605

Continuous Quality Improvement Program (CQIP), Reference No. 620

Fireline Paramedic Inventory, Reference No. 702

Management of Controlled Substances, Reference No. 710

EMT Scope of Practice, Reference No. 801

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

Emergency Medical Responder (EMR) Scope of Practice, Reference No. 804

Base Hospital/Modified Base Hospital Contact, Reference No. 812

Patient Initiated Release at Scene (RAS) or Patient Initiated Refusal of Service Against Medical Advice (AMA), Reference No. 850

Communication Failure, Reference No. 890
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SUBJECT: PATIENT DESTINATION

PURPOSE

To provide guidelines for determining the appropriate destination of patients transported in the S-SV EMS Region.

It is the intent of this policy to ensure, to the extent possible, that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

AUTHORITY

California Health & Safety Code, Division 2.5, Chapter 2 § 1797.67 & 1797.88, Chapter 6 § 1798.165 & 1798.170

California Code of Regulations, Title 13, § 1105(c)

California Code of Regulations, Title 22, Division 9, Chapters 2, 3, 4 & 7

POLICY

A. Determination of patient destination shall be governed by California Code of Regulations, Title 13, Section 1105 (c):

"In the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patients."

B. Hospitals unable to accept patients due to incapacitating internal disaster shall be considered not "prepared to receive emergency cases."

C. In determining the "most accessible" facility, transport personnel shall take into consideration traffic obstructions, weather conditions, or similar factors, which clearly affect transport time.

D. Receiving facilities shall maintain the current status of their facility on the regional electronic hospital alerting and assessment system (e.g., EMResource™), and shall update their facility status no less than once every 24 hours. Response to a request for inpatient bed polling (HAVBED) shall not exceed 30 minutes.
SUBJECT: PATIENT DESTINATION

GUIDELINES

A. "Most Accessible Medical Facility"

"The most accessible medical facility" shall ordinarily be the nearest licensed healthcare facility that maintains and operates a basic Emergency Department, except for:

1. Base/Modified Base Hospital Direction

   The base/modified base hospital may direct that the patient be transported to a further acute care hospital equipped, staffed, and prepared to receive emergency cases, which in the judgment of the base hospital physician or MICN, is more appropriate to the medical needs of the patient. Such direction shall take into consideration the prehospital provider agency’s stated and reasonable time and/or travel limitations.

2. Designated Special Care Facilities

   S-SV EMS Agency policies/protocols governing transport of special category patients to designated special care facilities shall be followed.

3. Control Facility Direction

   The Control Facility is responsible for the dispersal of all patients during Multi-Casualty Incidents.

4. Crisis Standard of Care

   In response to an unusual increased demand for emergency medical aid services beyond the capacity of the current system providers, Crisis Standard of Care Procedures may be implemented which may include EMS system alternate patient transportation and destination orders.

B. "Decisive Factors to the Contrary"

"Decisive factors to the contrary" include, but are not limited to, the following:

1. Prepaid Health Plans

   A member of a group practice prepayment health care service plan should be transported to a hospital that contracts with the plan when the base/modified base hospital determines that the condition of the member permits such transport. However, when the prehospital provider agency determines that such transport would unreasonably remove the transport unit from the area, the member may be transported to the nearest hospital capable of treating the member. (Health & Safety Code, Section 1797.106(b).)
2. Patient Requests

When a person or their legally authorized representative requests emergency transportation to a hospital other than the most accessible acute care hospital, the request should be honored when the base/modified base hospital determines that the condition of the patient permits such transport; except when the prehospital provider agency determines that such transport would unreasonably remove the transport unit from the area. In such cases:

a. Arrangements shall be made for alternative transport appropriate to the medical needs of the patient.

b. If such transport cannot be obtained without delay, the patient may be transported to the nearest hospital capable of treating him or her.

3. Private Physician’s Request

When a private physician requests emergency transportation to a hospital other than the most accessible acute care hospital, the request should be honored unless:

a. The base/modified base hospital determines that the condition of the patient does not permit such transport. In such cases, base/modified base hospital directions shall be followed. If communication with the requesting physician is feasible, the base/modified base hospital should contact the physician and explain the situation to him or her.

b. The prehospital provider agency determines that such transportation would unreasonably remove the unit from the area. In such cases:

- Arrangements should be made for alternate transportation appropriate to the medical needs of the patient.

- If alternate transportation cannot be arranged without unacceptable delay, and the private physician is immediately accessible, the patient may be transported to a mutually agreed-upon alternate destination.

- If alternate transportation cannot be arranged without unacceptable delay, and the private physician is not immediately accessible, the patient should be transported to the nearest hospital capable of treating him or her.
SUBJECT: PATIENT DESTINATION

CROSS REFERENCES:

Policy and Procedure Manual

Hospital Capabilities, Reference No. 505-A

Cardiovascular “STEMI” Receiving Centers, Reference No. 506

Stroke System Triage and Patient Destination, Reference No. 507

Base Hospital Contact, Reference No. 812

Multiple Casualty Incidents (MCI), Reference No. 837

Crisis Standard of Care Procedures, Reference No. 838

Trauma Triage Criteria, Reference No. 860

Chest Pain/Discomfort of Suspected Cardiac Origin, Reference No. C-8

Suspected CVA/Stroke, Reference No. N-3
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<th>Hospital Name</th>
<th>County</th>
<th>Base Mod. Base</th>
<th>Level I/II Trauma Center</th>
<th>Level III Trauma Center</th>
<th>Level IV Trauma Center</th>
<th>Labor and Delivery</th>
<th>Pediatric Trauma Center</th>
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<th>STEMI Receiving Center</th>
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**S-SV EMS MCI CONTROL FACILITIES**

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<th>Control Facility</th>
<th>County / Area of Responsibility</th>
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<td>Enloe Medical Center</td>
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<tr>
<td>Rideout Memorial Hospital</td>
<td>Sutter and Yuba Counties</td>
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<td>Sierra Nevada Memorial Hospital</td>
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<td>Sutter Roseville Medical Center</td>
<td>Western Slope of Placer County</td>
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<td>Tahoe Forest Hospital</td>
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<tr>
<td>Mercy Medical Center Redding</td>
<td>Shasta County/Siskiyou County/Tehama County</td>
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PURPOSE:

A Cardiovascular STEMI Receiving Center (SRC) will be the preferred destination for patients who access the 9-1-1 system meeting defined criteria and who show evidence of a ST-elevation myocardial infarction on a 12-Lead electrocardiogram.

AUTHORITY:

Health and Safety Code, Division 2.5, Chapter 2 § 1797.67 & 1797.88, Chapter 6 § 1798.102, 1798.150, 1798.170 & 1798.172

California Code of Regulations, Title 13, § 1105 (e), Title 22, Division 9, Chapter 4, § 100169

DEFINITIONS:

A. STEMI – ST Elevation Myocardial Infarction

B. PCI – Percutaneous Coronary Intervention

C. Cardiovascular STEMI Receiving Centers (SRC) – S-SV EMS Agency designated facilities that have emergency interventional cardiac catheterization capabilities

D. STEMI Referring Centers – Facilities that do not have emergency interventional cardiac catheterization capabilities

POLICY:

The following requirements must be met for a hospital to be designated as a Cardiovascular STEMI Receiving Center by the S-SV EMS Agency:

A. Be licensed by the California Department of Public Health Services as a general acute care hospital.

B. Have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5.
SUBJECT: CARDIOVASCULAR STEMI RECEIVING CENTERS

C. Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

D. Licensure as a Cardiac Catheterization Laboratory.

E. Intra-aortic balloon pump capability.

F. Cardiovascular surgical services permit:

This requirement may be waived by the S-SV EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with existing American College of Cardiology/American Heart Association or other existing professional guidelines for standards.

G. Communication system for notification of incoming STEMI patients, available twenty four (24) hours per day, seven (7) days per week including a dedicated 12-Lead ECG receiving station and an in-house paging system.

H. Provide CE opportunities, minimum of four (4) hours per year, for EMS personnel in areas of 12-Lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

I. Provide public education about STEMI warning signs and importance of early utilization the 9-1-1 system.

J. Staffing Requirements:

The hospital will have the following positions designated and filled prior to becoming a designated SRC:

1. Medical Directors:

   The hospital shall designate two physicians as co-directors of its SRC program. One physician shall be a board certified/eligible interventional cardiologist with active PCI privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

2. Nursing Directors:

   The hospital shall designate two SRC nursing co-directors. One nursing director shall be an RN trained or certified in critical care nursing and affiliated with the Cardiac Catheterization Laboratory. The co-director shall be an RN trained or certified in critical care nursing and affiliated with the emergency department.
3. On-Call Physician Consultants and Staff:

A daily roster of the following on-call physician consultants and staff must be maintained:

a. Cardiologist with percutaneous coronary intervention (PCI) privileges.

b. Cardiovascular Surgeon, if cardiovascular surgical services are offered.

If cardiovascular surgical services are not available on site, the facility must have a rapid transfer agreement in place with a facility that provides this service. This agreement must be on file with the S-SV EMS Agency. This agreement must include the requirement that the cardiac surgical hospital cannot “refuse” transfer based on limitation of resources (e.g. lack of available beds, or staff to care for the patient) for true emergent patients.

Additionally, the facility must have a rapid transport agreement with an S-SV EMS Agency approved transport provider agency. The expectation will be that the patient will arrive at the cardiac surgical hospital within one (1) hour of the decision to operate, in emergency cases.

c. Cardiac Catheterization Laboratory team.

d. Intra-aortic balloon pump capabilities 24/7.

K. Internal Hospital Policies:

The hospital shall develop internal policies for the following situations:

1. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI for a STEMI patient is not possible.

2. Diversion of STEMI patients only during times of an incapacitating internal disaster or when the cardiac catheterization laboratory is otherwise unavailable.

a. Notification shall be made to the following entities at least 24 hours prior to any planned event resulting in the cardiac cath lab being unavailable (e.g., routine cath lab maintenance):

   - S-SV EMS Agency
   - SRC emergency department - to include a status posting on the regional electronic hospital alerting and assessment system (e.g. EMResource™) indicating that the cardiac cath lab is unavailable
   - Appropriate Adjacent SRC (s)
   - Appropriate prehospital provider agencies
b. In the case of an unplanned event, the following entities shall be notified as soon as possible:

- SRC emergency department - to include a status posting on the regional electronic hospital alerting and assessment system (e.g. EMResource™) indicating that the cardiac cath lab is unavailable
- Appropriate Adjacent SRC(s)
- Appropriate prehospital provider agencies

A written notification describing such unplanned events shall be submitted to the S-SV EMS Agency by the end of the next business day.

c. All entities listed in this section shall be notified as soon as possible when the cardiac cath lab is subsequently available.

3. Prompt acceptance of appropriate STEMI patients from other STEMI referral centers that do not have PCI capability.

L. Data Collection/Continuous Quality Improvement Program/Performance Standards:

S-SV EMS Agency designated SRC’s shall comply with all data collection, continuous quality improvement and performance standards as defined in individual SRC facility contracts. These requirements will be the same for each SRC.

DESIGNATION

A. The Cardiovascular STEMI Receiving Center applicant shall be designated after satisfactory review of written documentation and an initial site survey by S-SV EMS or its designees and completion of a contract between the hospital and the S-SV EMS Agency.

B. Initial designation as a SRC shall be for a period of four (4) years. Thereafter, re-designation shall occur every four (4) years, contingent upon satisfactory review.

C. Failure to comply with the criteria and performance standards outlined in this policy and individual SRC facility contracts may result in probation, suspension or rescission of SRC designation. Compliance will be solely determined by the S-SV EMS Agency.

PATIENT DESTINATION

The following factors should be considered with regards to choice of destination for STEMI patients:
SUBJECT: CARDIOVASCULAR STEMI RECEIVING CENTERS

A. An S-SV EMS Agency designated SRC should be considered as the destination of choice if all of the following criteria are met:

1. Identified STEMI patients based on machine interpretation of field 12-Lead ECG, verified by a paramedic or Advanced EMT II.

2. Total transport time to the SRC is forty-five (45) minutes or less.

3. Prehospital personnel shall notify the SRC emergency department of the patient’s pending arrival by advising of a “STEMI ALERT” as soon as possible, to allow timely activation of the Cardiac Catheterization Lab team at the SRC.

B. SRC destination will be in accordance with the guidelines listed in the S-SV EMS Agency Patient Destination Policy, Reference No. 505.

C. Contact and consultation with the closest base/modified base hospital for appropriate patient destination shall be made in these and similar situations:

1. Patients in cardiac arrest or with an unmanageable airway should be considered for transport to the closest receiving hospital.

2. Patients with unstable ventricular tachycardia, second degree type II or third degree heart blocks, or with obvious contraindications to thrombolytic therapy should be directed to the closest SRC based on specific clinical scenario.

3. In the rare instance when the closest SRC Cardiac Catheterization Laboratory is unavailable, the patient should be transported to the next closest SRC if the total transport time to the alternate SRC is forty-five (45) minutes or less.

CROSS REFERENCES:

Prehospital Care Policy Manual
12 Lead EKG Program, Reference No. 440
Patient Destination, Reference No. 505
S-SV EMS Base/Receiving Hospital Capabilities, Reference No. 505-A
Interfacility Transport of Cardiovascular STEMI Patients, Reference No. 506-A
Base/Modified Base/Receiving Hospital Contact, Reference No. 812
Chest Pain or Suspected Symptoms of Cardiac Origin, Reference No. C-8
SUBJECT: EMERGENCY DEPARTMENT DOWNGRADE AND/OR CESSATION

PURPOSE:

To establish procedures for the evaluation of the potential impact on the Emergency Medical Services system due to the downgrade or closure of emergency medical services in hospitals.

AUTHORITY:

California Health and Safety Code, Division 2, Chapter 2, Sections 1255 and 1300

POLICY:

A. Any hospital proposing a reduction or elimination of emergency medical services in their facility shall notify the State Department of Health Services, the County Department of Public Health, the Sierra – Sacramento Valley EMS Agency and all health service plans under contract with the hospital, no later than 90 days prior to any such change.

B. The hospital implementing a change shall provide for public notification of the proposed changes no less than 90 days prior to implementing any changes. The notification shall be of such magnitude as to inform a significant number of residents within the hospital’s service area and be in terms likely to be understood by a layperson.

C. Upon notification, the Sierra – Sacramento Valley EMS Agency shall proceed with an Impact Evaluation in collaboration with the California Healthcare Association and the local Public Health Department. The report shall include, but is not limited to, the following areas:

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

2. Base hospital designation: Number of calls; impact on patients, prehospital personnel, and other base hospitals;

3. Level of care: Assessment of level of emergency services provided, i.e., basic, standby, and next nearest availability;
SUBJECT: EMERGENCY DEPARTMENT DOWNGRADE AND/OR CESSIONATION

4. **Trauma care**: Number of trauma patients; impact on other hospitals, trauma centers, and trauma patients;

5. **Specialty services provided**: Neurosurgery, obstetrics, burn center, pediatric critical care etc., and the next nearest availability;

6. **Patient volume**: Number of patients annually, both 911 transports and walk-ins;

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

8. **Availability of prehospital care**: Availability and level of prehospital care and EMS aircraft resources;

9. **Public and emergency provider comments**: Obtained through local EMS committees and public hearing;

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

D. Within 45 days of notification, the Sierra – Sacramento Valley EMS Agency shall:

1. Ensure planning or zoning authorities have been notified

2. Conduct, in conjunction with the local Department of Public Health, at least one public hearing on the proposed changes

3. Distribute a draft of the report to the local county Department of Public Health, the Medical Control Committee, the affected county’s Emergency Medical Control Committee (or similar county EMS committee), the Joint Powers Agency Governing Board, and any other emergency care providers affected by the changes.

E. The Sierra – Sacramento Valley EMS Agency shall submit the impact evaluation report (no more than 60 days after notification) to the State Department of Health Services, the State EMS Authority, and the area’s Emergency Medical Care Committee (or similar county EMS committee), the Joint Powers Agency Governing Board, and the Medical Control Committee.
SIERRA-SACRAMENTO VALLEY EMS AGENCY

DOCUMENTATION/QUALITY IMPROVEMENT
SECTION VI

SUBJECT: INDEX  REFERENCE NO. 600

605  Prehospital Documentation

605-A  Transfer of Care/Interim Pt. Care Report Form

620  Continuous Quality Improvement Program (CQIP)
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<table>
<thead>
<tr>
<th>SUBJECT: INDEX</th>
<th>REFERENCE NO. 700</th>
</tr>
</thead>
<tbody>
<tr>
<td>701</td>
<td>Prehospital Provider Agency Inventory Requirements</td>
</tr>
<tr>
<td>702</td>
<td>Fireline Paramedic Inventory</td>
</tr>
<tr>
<td>705</td>
<td>Prehospital Provider Agency Unit Inspection</td>
</tr>
<tr>
<td>706</td>
<td>Equipment and Supply Shortages</td>
</tr>
<tr>
<td>710</td>
<td>Management of Controlled Substances</td>
</tr>
<tr>
<td>715</td>
<td>Biomedical Equipment Maintenance</td>
</tr>
</tbody>
</table>
SUBJECT: PREHOSPITAL PROVIDER AGENCY INVENTORY REQUIREMENTS

PURPOSE:

To establish a standardized inventory on all S-SV EMS Agency approved EMS response vehicles.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220
California Code of Regulations, Title 22, Division 9
California Code of Regulations, Title 13
California Vehicle Code, Section 2418.5
Emergency Medical Services Authority Guidelines and Recommendations, Highway Patrol Handbook 82.4

POLICY:

All S-SV EMS Agency approved EMS response vehicles shall carry the following equipment and supply inventory. Reasonable variations may occur; however, any exceptions or additions shall have prior approval of the S-SV EMS Agency.

For inventory list see attached table
# Sierra-Sacramento Valley EMS Agency
## EQUIPMENT AND SUPPLY SPECIFICATIONS

### RADIO EQUIPMENT

<table>
<thead>
<tr>
<th></th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile UHF Med-Net Radio</td>
<td>1</td>
<td>Opt. - 1</td>
<td>0</td>
<td>1</td>
<td>Opt. - 1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Portable UHF Med-Net Radio OR Portable Cell Phone</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

### MISCELLANEOUS EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maps (paper or electronic covering the areas where service is provided)</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>D.O.T Emergency Response Guidebook</td>
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<td>1</td>
<td>1</td>
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<td>FIRESCOPE Field Operations Guide (FOG)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Hazardous Materials medical management reference</td>
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<td>1</td>
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<td>1</td>
<td>1</td>
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<td>Approved ePCR</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>Optional</td>
<td>Optional</td>
</tr>
<tr>
<td>RAS/AMA Forms</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>Optional</td>
</tr>
<tr>
<td>Triage Tags (included in triage kit for transport providers)</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Triage Kit in a folio or gear bag to include the following minimum items: MCI vests for Triage and Medical Group Supervisor positions, pens/pencils, trauma sheers, clipboard, Patient Trasnportation Summary Worksheets, START Triage reference sheet, barrier tape, and glow sticks</td>
<td>1</td>
<td>Opt. - 1</td>
<td>0</td>
<td>1</td>
<td>Opt. - 1</td>
<td>1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>Infection control packs (per crew member)</td>
<td>1 pk each</td>
<td>1 pk each</td>
<td>1 pk</td>
<td>1 pk each</td>
<td>1 pk each</td>
<td>1 pk each</td>
<td>1 pk each</td>
</tr>
<tr>
<td>Antiseptic hand wipes or waterless hand sanitizer</td>
<td>10/1</td>
<td>10/1</td>
<td>5/1</td>
<td>10/1</td>
<td>10/1</td>
<td>10/1</td>
<td>10/1</td>
</tr>
<tr>
<td>Covered waste container (red bio hazard bags acceptable)</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult &amp; Pediatric BP cuff</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Thigh BP cuff</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Flashlight or Penlight</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bedpan or Fracture pan</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>Urinal</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sharps container</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Padded soft wrist &amp; ankle restraints</td>
<td>1 set</td>
<td>Opt. - 1 set</td>
<td>0</td>
<td>1 set</td>
<td>Opt. - 1 set</td>
<td>1 set</td>
<td>0</td>
</tr>
<tr>
<td>Pillows, sheets, pillow cases, towels</td>
<td>2 each</td>
<td>0</td>
<td>0</td>
<td>2 each</td>
<td>0</td>
<td>2 each</td>
<td>0</td>
</tr>
<tr>
<td>Blankets</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Emesis basin/disposable emesis bags</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Length based Pediatric Resuscitation Tape (Broselow)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ambulance cot with straps to secure patient to cot and necessary equipment to properly secure cot in vehicle</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
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*Updated 06/01/2013*
# Sierra-Sacramento Valley EMS Agency
## Equipment and Supply Specifications

### MISCELLANEOUS EQUIPMENT & SUPPLIES (continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collapsible stretcher, breakaway flat, or similar device</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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</table>

### BIOMEDICAL EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse Oximeter</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Opt. - 1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>Automatic External Defibrillator (AED) - with adult patches (pediatric patches are recommended but optional).</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1*</td>
<td>1*</td>
<td>Opt. - 1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>AED with cardiac monitoring and manual defibrillation capabilities (in place of portable monitor/defibrillator for bike teams only)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Portable Monitor/Defibrillator - battery operated, with ECG printout, capable of synchronized cardioversion, transcutaneous pacing &amp; 12-Lead (waveform capnography optional).</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1*</td>
<td>1*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spare monitor/defibrillator/AED battery</td>
<td>1</td>
<td>1</td>
<td>as needed</td>
<td>1</td>
<td>1</td>
<td>as needed</td>
<td>as needed</td>
</tr>
<tr>
<td>Adult hands free defibrillator patches OR defibrillator paddles with defibrillation gel pads or paddle conduction gel</td>
<td>2 sets</td>
<td>2 sets</td>
<td>2 sets</td>
<td>2 sets</td>
<td>2 sets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric hands free defibrillator patches OR defibrillator paddles with defibrillation gel pads or paddle conduction gel</td>
<td>1 set</td>
<td>1 set</td>
<td>1 set</td>
<td>1 set</td>
<td>1 set</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Electrode leads (wires) *(AEMT II Providers Only)</td>
<td>2 sets</td>
<td>1 set</td>
<td>1 set</td>
<td>2 sets*</td>
<td>1 set*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ECG paper *(AEMT II Providers Only)</td>
<td>2 rolls</td>
<td>1 roll</td>
<td>as needed</td>
<td>2 sets*</td>
<td>1 set*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult/pediatric disposable ECG electrodes (10/set) *(AEMT II Providers Only)</td>
<td>4 sets</td>
<td>2 sets</td>
<td>2 sets</td>
<td>4 sets</td>
<td>2 sets</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Co-Oximeter (optional)</td>
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<td>Opt. - 1</td>
<td>Opt. - 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Glucometer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Glucometer test strips</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>5</td>
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<tr>
<td>Lancets</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Required in place of portable monitor/defibrillator and supplies listed in this section for LALS providers who utilize non-AEMT II personnel.

Updated 06/01/2013
# Sierra-Sacramento Valley EMS Agency
## EQUIPMENT AND SUPPLY SPECIFICATIONS

<table>
<thead>
<tr>
<th>AIRWAY/OXYGEN EQUIPMENT &amp; SUPPLIES</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;H&quot; or &quot;M&quot; oxygen tank mounted in ambulance</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Wall mounted oxygen regulator with liter flow mounted in ambulance</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>&quot;D&quot; or &quot;E&quot; portable oxygen cylinder (&quot;C&quot; size acceptable for bike teams)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Portable oxygen regulator with liter flow</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult non-rebreather oxygen mask</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric oxygen mask</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>Nasal cannula</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Hand held nebulizer</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aerosol/nebulizer mask</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bag-Valve Device - Adult (1000 cc bag vol.)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bag-Valve Device - Pediatric (450 - 500 cc bag vol.)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bag-Valve Mask (transparent) - small, medium &amp; large adult</td>
<td>1 each</td>
<td>1 each</td>
<td>1 - large</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Bag-Valve Mask (transparent) - child &amp; neonate</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Oropharyngeal Airways (sizes 0-6 or equivalent sizes)</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Nasopharyngeal Airways (sizes 24-34 Fr. or equivalent sizes)</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Water soluble lubricant (K-Y jelly or equivalent)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Vehicle mounted suction unit</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Portable mechanical suction unit (hand held manual suction device with adult and pediatric tubes acceptable for bike teams or BLS non-transport)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Spare suction canisters/bags with lids</td>
<td>2</td>
<td>Opt. -1</td>
<td>0</td>
<td>2</td>
<td>Opt. -1</td>
<td>2</td>
<td>Opt. -1</td>
</tr>
<tr>
<td>Tonsilar tip suction handle (if not using hand held manual suction device)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Suction catheters - 6 fr, 8 fr, 10 fr, 14 fr</td>
<td>2 each</td>
<td>1 each</td>
<td>0</td>
<td>2 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Laryngoscope handle (adult &amp; pediatric)</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Batteries - extra set</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bulb - extra bulb for adult and pediatric blade (if not using disposable blades)</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Miller (straight blade) sizes 0-4</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Macintosh (curved blade) sizes 3-4</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Magill forceps - adult &amp; pediatric</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Topical vasoconstrictor (Neosynephrine or equivalent)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2% Lidocaine jelly</td>
<td>1 tube</td>
<td>1 tube</td>
<td>1 tube</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Uncuffed endotracheal tubes, sizes 2.5, 3.0</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>

Updated 06/01/2013
## Sierra-Sacramento Valley EMS Agency
### EQUIPMENT AND SUPPLY SPECIFICATIONS

#### AIRWAY/OXYGEN EQUIPMENT & SUPPLIES (cont.)

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuffed endotracheal tubes, sizes 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Endotracheal tube stylettes - neonatal, child &amp; adult</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Flex Guide ETT introducer - caude tip 15 fr x 70 cm</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Advanced Airway tube holder</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2*</td>
<td>1*</td>
</tr>
<tr>
<td>*S-SV EMS approved EMT optional skill providers only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Esophageal Tracheal Airway Device - Adult 37 and 41 Fr OR King Airway Device - Size 3, Size 4, Size 5</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each*</td>
<td>1 each*</td>
</tr>
<tr>
<td>*S-SV EMS approved EMT optional skill providers only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End tidal CO2 detector device - disposable single patient use colorimetric device (adult &amp; pediatric) or disposable capnography/capnometer circuit</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
<td>2 each*</td>
<td>1 each*</td>
</tr>
<tr>
<td>*S-SV EMS approved EMT optional skill providers only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Esophageal Intubation Detector Device (EDD) (optional for ALS providers using waveform capnography or capnometer)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td>*S-SV EMS approved EMT optional skill providers only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meconium aspirator</td>
<td>1</td>
<td>Opt. - 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Airway airflow monitor (optional)</td>
<td>Opt. - 2</td>
<td>Opt. - 2</td>
<td>Opt. - 1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>S-SV approved disposable CPAP circuit with mask</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual Jet Ventilator device (including Adult &amp; Pediatric Transtracheal Catheter or minimum 12 ga x 3 &quot; catheter) OR ENK Flow Modulator Kit</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Needle thoracostomy kit with minimum 14 ga X 3 &quot; catheter specifically designed for needle decompression</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
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</table>

#### IMMOBILIZATION EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ked</td>
<td>1</td>
<td>Opt. - 1</td>
<td>0</td>
<td>1</td>
<td>Opt. - 1</td>
<td>1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>Long spine board with straps</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric spine board</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>Head immobilization set</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Traction splint: Hare, Sager or equivalent</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Opt. - 1</td>
</tr>
<tr>
<td>Arm &amp; leg splints (i.e. cardboard, SAM type, vacuum)</td>
<td>2 each</td>
<td>2 each</td>
<td>0</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
</tr>
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Updated 06/01/2013
# Sierra-Sacramento Valley EMS Agency
## EQUIPMENT AND SUPPLY SPECIFICATIONS

### IMMOBILIZATION EQUIPMENT & SUPPLIES (continued)

<table>
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<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Collars (rigid): Large, medium, small &amp; pediatric OR adjustable adult &amp; pediatric</td>
<td>2 each</td>
<td>2 each</td>
<td>Opt. - 1 ea.</td>
<td>2 each</td>
<td>2 each</td>
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</tbody>
</table>

### OBSTETRICAL EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB Kit containing a minimum: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe, stocking cap, and clean plastic bags.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
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### BANDAGING EQUIPMENT & SUPPLIES

<table>
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<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band-Aids</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Adhesive tape rolls 1&quot; &amp; 2&quot; rolls</td>
<td>2 each</td>
<td>1 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Non sterile 4x4 compresses</td>
<td>50</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>50</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Sterile 4x4 compresses</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Trauma dressing (10&quot;x30&quot; or larger universal dressings)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Kling/Kerlix in 2&quot;, 3&quot; or 4&quot; rolls</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Sterile petroleum impregnated dressing</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Triangle bandages</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Cold packs and heat packs</td>
<td>4 each</td>
<td>2 each</td>
<td>2 each</td>
<td>4 each</td>
<td>2 each</td>
<td>4 each</td>
<td>2 each</td>
</tr>
<tr>
<td>Gloves (unsterile) various sizes</td>
<td>10 pr each</td>
<td>10 pr each</td>
<td>2 pr each</td>
<td>10 pr each</td>
<td>10 pr each</td>
<td>10 pr each</td>
<td>10 pr each</td>
</tr>
<tr>
<td>1000 mL sterile irrigation solution</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Potable water</td>
<td>2 liters</td>
<td>2 liters</td>
<td>0</td>
<td>2 liters</td>
<td>1 liter</td>
<td>2 liters</td>
<td>1 liter</td>
</tr>
<tr>
<td>Bandage shears</td>
<td>1 pr</td>
<td>1 pr</td>
<td>1 pr</td>
<td>1 pr</td>
<td>1 pr</td>
<td>1 pr</td>
<td>1 pr</td>
</tr>
</tbody>
</table>

### IV/MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter over needle - 14 ga, 16 ga, 18 ga, 20 ga</td>
<td>6 each</td>
<td>2 each</td>
<td>2 each</td>
<td>6 each</td>
<td>2 each</td>
<td>6 each</td>
<td>0</td>
</tr>
<tr>
<td>Catheter over needle - 22ga, 24ga</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>0</td>
</tr>
<tr>
<td>Micro-drip &amp; Macro-drip venosets OR Selectable drip tubing</td>
<td>4 each</td>
<td>2 each</td>
<td>1 each</td>
<td>4 each</td>
<td>2 each</td>
<td>0</td>
<td>0</td>
</tr>
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</table>

Updated 06/01/2013
## Sierra-Sacramento Valley EMS Agency
### Equipment and Supply Specifications

#### IV/Medication Administration Equipment & Supplies (cont.)

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV extension</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IV start pack or equivalent with tourniquets</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol wipes</td>
<td>20</td>
<td>10</td>
<td>5</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Chlorhexidine swabs/skin prep</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>optional</td>
<td>optional</td>
</tr>
<tr>
<td>TB/1 mL syringe</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 - 5 mL syringe</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10 - 12 mL syringe</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20 mL syringe</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>50 - 60 mL syringe</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22 ga, 25 ga safety injection needles</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>2 each</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Filter needle (only required if utilizing medication in ampules)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vial access cannulas</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mucosal Atomization Device (MAD)</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Arm boards - (short, long)</td>
<td>2 each</td>
<td>1 each</td>
<td>0</td>
<td>2 each</td>
<td>1 each</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vacutainer holder, needle &amp; blood tubes (optional)</td>
<td>Optional</td>
<td>Optional</td>
<td>0</td>
<td>Optional</td>
<td>Optional</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10 mL NS vials or pre-filled syringes for injection/flush</td>
<td>Opt. - 2</td>
<td>Opt. - 1</td>
<td>Opt. - 1</td>
<td>Opt. - 2</td>
<td>Opt. - 1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Intraosseous Access Equipment & Supplies

ALS providers must stock the necessary equipment and supplies to establish IO access on both an adult and pediatric patient/LALS providers must stock the necessary equipment and supplies to establish IO access on a pediatric patient as indicated below:

**Pediatric IO Devices** (ALS/LALS providers must stock one of the following devices in the minimum quantity listed)

<table>
<thead>
<tr>
<th>Device</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamshidi® Illinois device with 15 ga adjustable length needle</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bone Injection Gun (B.I.G.®) - Pediatric</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EZ-IO® 15 mm Pediatric Needle Set (including a minimum of 1 EZ-IO® Power Driver used for both adult and pediatric patients)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Adult IO Devices** (ALS providers must stock one of the following devices in the minimum quantity listed)

<table>
<thead>
<tr>
<th>Device</th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Injection Gun (B.I.G.®) - Adult</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EZ-IO® Adult Needle Set (including a minimum of 1 EZ-IO® Power Driver used for both adult and pediatric patients). At least one needle set shall be 45 mm length</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>
# Sierra-Sacramento Valley EMS Agency
## Equipment and Supply Specifications

### Minimum Quantity Required

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<tr>
<th></th>
<th>ALS Transport</th>
<th>ALS Non Transport</th>
<th>ALS BIKES</th>
<th>LALS Transport</th>
<th>LALS Non Transport</th>
<th>BLS Transport</th>
<th>BLS Non Transport</th>
</tr>
</thead>
</table>

### IV Solutions

- **Lactated Ringers - 1000 mL bag (optional)**
  - Opt. - 2
  - Opt. 1
  - 0
  - Opt. - 2
  - Opt. - 1
  - 0
  - 0

- **Normal saline - 1000 mL bag**
  - 8
  - 6
  - 2
  - 2
  - 6
  - 2
  - 0
  - 0

- **Normal saline - 250 mL bag**
  - 2
  - 2
  - 1
  - 0
  - 2
  - 1
  - 0
  - 0

### Medications

#### Activated charcoal (50 gm)
- 1
- Opt. - 1
- 0
- 1
- Opt. - 1
- 0
- 0

#### Adenosine 6 mg - vial or pre-filled syringe
- 6
- 5
- 4
- 3
- 2
- 3
- 0
- 0

#### Albuterol - 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5 mL, without preservatives, is required for dilution of each dose.
- 6
- 4
- 2
- 6
- 4
- 0
- 0

#### Amiodarone 3 ml - 150 mg (50 mg/ml)
- 6
- 3
- 3
- 0
- 0
- 0
- 0

#### Aspirin (chewable)
- 8
- 8
- 8
- 8
- 8
- 8
- 0
- 0

#### Atropine 1 mg/1ml vial or 1 mg/10 ml preload syringe
- *LALS providers who use AEMT II personnel only*
- 4
- 2
- 2
- 4*
- 2*
- 0
- 0

#### Benadryl (50 mg/ml)
- 2
- 2
- 2
- 0
- 0
- 0
- 0

#### Benadryl elixir - 100 mg
- 1
- 1
- 1
- 0
- 0
- 0
- 0

#### Calcium Chloride 10% - (1 gm/10ml)
- 4
- 2
- 2
- 0
- 0
- 0
- 0

#### Dextrose 50% (25gm/50ml)
- 2
- 2
- 1
- 2
- 2
- 0
- 0

#### Dextrose 25% (2.5gm/10ml)
- 2
- 1
- 0
- 2
- 1
- 0
- 0

#### Dopamine 400 mg
- 1
- Opt. - 1
- 0
- 0
- 0
- 0
- 0

#### Epinephrine 1:1,000 Auto Injector: Adult 0.3 mg/Pediatric 0.15 mg
- *S-SV EMS Agency approved EMT Optional Skill providers only*
- 0
- 0
- 0
- 0
- 0
- Opt. - 1 ea*
- Opt. - 1 ea*

#### Epinephrine 1:1,000
- 5 mg
- 5 mg
- 5 mg
- 5 mg
- 5 mg
- 0
- 0

#### Glucagon 1mg (1unit)
- 1
- 1
- 1
- 1
- 1
- 0
- 0

#### Glucose paste OR Glucose solution (oral prepackaged)
- 2
- 1
- 1
- 2
- 1
- 1
- 0

#### Lidocaine HCl 2% (100mg/5ml) - IO use ALS/antiarrhythmic LALS
- *LALS providers who use AEMT II personnel only*
- 1
- 1
- 1
- 6*
- 3*
- 0
- 0

#### Mark-I/Duo Dote Nerve Agent Antidote Kits
- *S-SV EMS Agency approved EMT Optional Skill providers only*
- Optional
- Optional
- Optional
- Optional
- Optional
- Optional*
- Optional*

#### Midazolam (Versed) 5 mg/ml concentration (minimum-maximum)
- *LALS providers who use AEMT II personnel only*
- 20-60 mg
- 20-60 mg
- Optional - up to 20 mg
- 20-60 mg*
- 20-60 mg*
- 0
- 0

---

Updated 06/01/2013
<table>
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<tr>
<th>MEDICATIONS (cont.)</th>
<th>MINIMUM QUANTITY REQUIRED</th>
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<tr>
<td></td>
<td>ALS Transport</td>
</tr>
<tr>
<td>Morphine HCL 10 mg/ml unit dose (minimum-maximum) *LALS providers who use AEMT II personnel only</td>
<td>20-100 mg</td>
</tr>
<tr>
<td>Naloxone (Narcan) 2.0 mg</td>
<td>4</td>
</tr>
<tr>
<td>Nitroglycerin 0.4 mg/tab (1/150) bottle OR Nitroglycerine spray actuation</td>
<td>2</td>
</tr>
<tr>
<td>Pralidoxime Chloride (2-PAM) 1 gm/20 ml vial (optional)</td>
<td>Optional</td>
</tr>
<tr>
<td>Sodium Bicarbonate (50mEq/50ml) *LALS providers who use AEMT II personnel only</td>
<td>2</td>
</tr>
<tr>
<td>Zofran (4mg/2ml vial)</td>
<td>8</td>
</tr>
<tr>
<td>Zofran Oral Disintegrating Tablets (ODT) 4 mg</td>
<td>4</td>
</tr>
<tr>
<td>Double lock container system for controlled meds *LALS providers who use AEMT II personnel only</td>
<td>1</td>
</tr>
<tr>
<td>Controlled substance log sheet *LALS providers who use AEMT II personnel only</td>
<td>1</td>
</tr>
</tbody>
</table>
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REMOVE
Policies
703 & 704
PURPOSE

To conduct annual and periodic unannounced inspections that ensure prehospital provider agencies remain in compliance with the S-SV EMS Agency Prehospital Provider Agency Inventory Requirements Policy (Reference No. 701).

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220
California Code of Regulations, Title 22, Division 9
California Vehicle Code, Section 2418.5
Emergency Medical Services Authority Guidelines and Recommendations, Highway Patrol Ambulance Driver’s Handbook 82.4, Title 13

POLICY

The S-SV EMS Agency Regional Executive Director or their authorized agent shall conduct annual and periodic unannounced unit inspections of all BLS/ALS/LALS transport and ALS/LALS non-transport provider agencies within the S-SV EMS region. The inspections shall occur once a year as scheduled or any time without prior notice.

PROCEDURE

A. Annual Inspections

1. An authorized S-SV EMS Agency representative shall contact the prehospital provider agency to schedule annual inspections.

2. The prehospital provider agency shall coordinate the rotation of the units to be inspected to prevent removing all available units from service at one time.

3. The annual inspection will consist of a complete examination of S-SV EMS Agency required equipment and supplies per S-SV EMS Agency Prehospital Provider Agency Inventory Requirements Policy (Reference No. 701).
SUBJECT: PREHOSPITAL PROVIDER AGENCY UNIT INSPECTIONS

4. The inspection shall include random visual inspection of expiration dates on medications and supplies.

5. The inspection shall also include operation of all required equipment, including a test of the med net radio.

6. The S-SV EMS Agency authorized representative shall also examine the unit’s controlled substances and written records of controlled substance inventory and administration, if applicable, for compliance with S-SV EMS Agency ‘Management of Controlled Substances’ policy, Reference No. 710.

B. Unannounced Inspections

1. Upon arrival to conduct an unannounced inspection, the S-SV EMS Agency representative shall notify a crew member on the unit to be inspected of the intent to conduct an inspection.

2. The unit shall not be removed from service; however, their dispatch shall be notified of the inspection.

3. In the event an emergency call comes in and it is necessary for the unit to respond, the inspection will be discontinued.

4. When conducting the inspection the S-SV EMS Agency representative will randomly inspect the unit’s required equipment and supplies (including expiration dates).

C. General Information

1. In the event the S-SV EMS Agency representative determines the unit being inspected has a deficiency with equipment or supplies; the representative may advise the supervisor of the unit that there is a deficiency and give the supervisor the opportunity to correct the deficiency immediately. If the supervisor cannot correct the deficiency and the Agency representative feels the deficiency may compromise patient care, the unit may be removed from service until corrections are made.

2. The S-SV EMS Agency representative will complete an inspection form for every unit inspected.

   a. The inspection form will indicate if it was an annual or unannounced inspection as well as any deficiencies or issues identified.

   b. Completed inspection reports will be maintained at the S-SV EMS Agency office.
3. The prehospital provider agency representative will be notified of the inspection and its outcome.

CROSS REFERENCES

Prehospital Care Policy Manual

Prehospital Provider Agency Inventory Requirements, Reference No. 701

Fireline Paramedic Inventory, Reference No. 702

Equipment and Supply Shortages, Reference No. 706

Management of Controlled Substances, Reference No. 710
SUBJECT: MANAGEMENT OF CONTROLLED SUBSTANCES

PURPOSE

To ensure accountability for all controlled substances obtained, maintained and utilized by ALS (paramedic) and applicable LALS (AEMT II) prehospital provider agencies and personnel in the S-SV EMS region.

AUTHORITY

Code of Federal Regulations, Title 21
California Health & Safety Code, Division 10
California Health & Safety Code, Division 2.5
California Code of Regulations, Title 22, Division 9, Chapters 3 & 4

POLICY

A. S-SV EMS Agency approved controlled substances

1. Midazolam (Versed)
2. Morphine Sulfate

B. ALS and applicable LALS prehospital service provider agencies shall obtain controlled substances through the following methods:

1. The medical director of the provider agency, or;
2. The base/modified base hospital shall ensure that a mechanism exists for prehospital providers to contract for the provision of controlled substances.

C. Prehospital Service Provider Agency Policies and Procedures

1. ALS and applicable LALS prehospital service provider agencies shall ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:
a. Controlled substance ordering and order tracking

b. Controlled substance receipt and accountability

c. Controlled substance master supply storage, security and documentation

d. Controlled substance labeling and tracking

e. Controlled substance vehicle storage and security

f. Controlled substance usage procedures and documentation

g. Controlled substance reverse distribution

h. Controlled substance disposal

i. Controlled substance re-stocking procedures

2. ALS and applicable LALS prehospital service provider agencies shall ensure that mechanisms for investigation and mitigation of suspected controlled substance tampering or diversion are established, including, but not limited to:

   a. Controlled substance testing

   b. Controlled substance discrepancy reporting

   c. Controlled substance tampering, theft and diversion prevention and detection

   d. Controlled substance usage audits.

D. Security of Narcotics

1. Paramedics and AEMT IIs assigned to ALS/LALS units shall be responsible for maintaining the correct inventory of controlled substances at all times.

2. All controlled substances shall be secured on the ALS/LALS units under double lock. The units outside driver/passenger/patient access door(s) shall not be considered one of the two locks.

3. ALS/LALS prehospital service provider agencies must abide by all Federal, State and local regulations for the storage of controlled substances, including those utilized for restocking of ALS/LALS units.

4. Each ALS/LALS unit shall maintain a standardized written record of the controlled substance inventory. That record shall be considered a permanent record. Once completed, controlled substance inventory and administration
records shall be maintained in accordance with State and Federal Law and Regulation.

5. Controlled substances shall be inventoried any time there is a change in personnel. The key to access controlled substances shall be in the custody of the individual who performed the inventory.

6. Any discrepancies in the controlled substance count shall be reported to the ALS/LALS provider supervisor/management and to the issuing agent (e.g., prehospital service provider agency medical director). The discrepancy report must be in writing.

E. Controlled Substances Administered to Patients

1. Controlled substances are to be administered in accordance with S-SV EMS Agency treatment protocols.

2. The following information must be documented on a controlled substance administration record.
   a. Date administered
   b. Time administered
   c. Unit number
   d. Patient name
   e. Drug administered
   f. Amount administered
   g. Paramedic/AEMT II signature and number
   h. If only a portion of the medication was administered to the patient, the remainder shall be wasted in the presence of a registered nurse or physician at the receiving hospital, or the ALS/LALS service provider’s immediate supervisor. Both parties shall document this action on the controlled substance administration form.

3. Controlled substance inventories and logs are subject to inspection by inspectors of the California Board of Pharmacy, agents of the Bureau of Narcotic Enforcement Administration of the Justice Department, Federal Drug Enforcement Administration, the S-SV EMS Agency, issuing agent, and officers of the provider agency.
SUBJECT: MANAGEMENT OF CONTROLLED SUBSTANCES

CROSS REFERENCES

Prehospital Care Policy Manual

Prehospital Provider Agency Inventory Requirements, Reference No. 701

AEMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803
SUBJECT: BIOMEDICAL EQUIPMENT MAINTENANCE

PURPOSE

To ensure all prehospital provider agencies have a maintenance program for all biomedical equipment used in the prehospital setting.

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220

California Code of Regulations, Title 22, Division 9, Chapter 1.5, § 100021, Chapter 2, § 100063.1 & 100064, Chapter 4, §100167, Chapter 8, § 100306, and Chapter 12, § 100402 & 100404

POLICY

A. All prehospital provider agencies in the S-SV EMS Region shall have a maintenance program for all biomedical equipment utilized for patient care in the prehospital setting.

B. The periodic preventative maintenance on all biomedical equipment shall meet or exceed the criteria recommended by the manufacturer.

C. Individuals performing scheduled maintenance or repair shall possess the necessary credentials recommended by the manufacturer.

D. Prehospital provider agencies shall immediately remove from service any biomedical equipment suspected of malfunctioning. Any malfunctioning biomedical equipment shall not be placed into service until properly serviced or repaired by the manufacturer or manufacturer’s authorized service program.

E. Any biomedical equipment suspected of malfunctioning, that may have adversely affected patient care shall be:

1. Immediately reported to an on-duty prehospital provider agency supervisor.

2. Immediately reported to the RN or physician staff at the receiving facility if the malfunctioning equipment impacted or has a potential to impact patient health and well being.
3. Reported to the S-SV EMS Agency by the end of the next business day. This report shall include, service provider’s name, date of incident, type of device, model number, serial number, patient’s name, ePCR number, description of incident, affect on patient care, and description of all actions taken at the time of reporting and current location of equipment.

F. Records documenting compliance with this policy shall be subject to review and inspection by the S-SV EMS Agency.
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</tr>
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- C-1 Pulseless Arrest
- C-5 Return of Spontaneous Circulation (ROSC)
- C-6 Tachycardia with Pulses
- C-7 Bradycardia
- C-8 Chest Pain or Suspected Symptoms of Cardiac Origin

**Respiratory**
- R-1 Airway Obstruction
- R-2 Respiratory Arrest
- R-3 Acute Respiratory Distress
- R3-A Continuous Positive Airway Pressure (CPAP)

**Medical**
- M-1 Allergic Reaction/Anaphylaxis
- M-2 Shock/Non-Traumatic Hypovolemia
- M-3 Phenothiazine/Dystonic Reaction
- M-5 Ingestions and Overdoses
- M-5-A Guidelines for EMS Use of Activated Charcoal
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SIERRA-SACRAMENTO VALLEY EMS AGENCY

FIELD POLICIES & TREATMENT PROTOCOLS
SECTION VIII

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SUBJECT: EMT SCOPE OF PRACTICE

PURPOSE:

To define the Emergency Medical Technician (EMT) scope of practice in the S-SV EMS region.

AUTHORITY:

California Health & Safety Code, Division 2.5, Sections 1797.107, 1797.109, 1797.160, 1797.170, 1797.220 and 1797.80.

California Code of Regulations, Title 22, Division 9, Chapter 2, Sections 100063 & 100064.

POLICY:

A. During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:

1. Evaluate the ill and injured.

2. Render basic life support, rescue, and emergency medical care to patients.

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

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

5. Administer oxygen.

6. Use the following adjunctive airway breathing aids:

   a. Oropharyngeal airway;
   b. Nasopharyngeal airway;
   c. Suction devices;
   d. Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
SUBJECT: EMT SCOPE OF PRACTICE

e. Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure (CPAP).

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

8. Provide initial prehospital emergency care of trauma, including, but not limited to:

   a. Bleeding control through the application of tourniquets;
   b. Use of hemostatic dressings;
   c. Spinal immobilization;
   d. Seated spinal immobilization;
   e. Extremity splinting; and
   f. Traction splinting.

9. Administer oral glucose or sugar solutions.

10. Extricate entrapped persons.

11. Perform field triage.

12. Transport patients.

13. Mechanical patient restraint.

14. Set up for ALS procedures, under the direction of an Advanced EMT or paramedic.

15. Perform automated external defibrillation.

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

B. In addition to the activities authorized by section A of this policy, a certified EMT or a supervised EMT student in the prehospital setting and/or during interfacility transport may:

1. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement if:

   a. The patient is non-critical and deemed stable by the transferring or base hospital physician and the physician approves transport by an EMT.

   b. Nothing has been added to the intravenous fluids and, in the prehospital setting, no other ALS procedures have been initiated.
SUBJECT: EMT SCOPE OF PRACTICE

c. The EMT may monitor, maintain, and adjust, if necessary, in order to maintain a preset rate of flow and turn off the flow of intravenous fluid.

2. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines. Utilizing the following guidelines:

a. Nasogastric Tubes:
   - Nasogastric tubes shall be clamped. No form of suction shall be allowed during transport.
   - 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.
   - Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
   - Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowlers position to help prevent the possibility of aspiration.

b. Abdominal Tubes (Gastrostomy tubes, ureterostomy tubes, wound drains, etc.):
   - EMTs 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.
   - Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
   - Any dressing drainage shall be noted and charted.
   - 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.

c. Foley Catheters:
   - 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.
Subject: EMT Scope of Practice

- Amount and characteristics of urine shall be noted.

- 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.

D. Tracheostomy Tubes:

- Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.

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

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

3. Transfer a patient that has a physician prescribed, locked down, patient operated medication pump.

C. Optional Skills:

Certified EMT personnel may utilize the following optional skills, when employed with an approved EMT Optional Skill service provider and accredited to use that optional skill:

1. Use an Esophageal Tracheal Airway device (ETAD) on an unconscious patient with an absent gag reflex, who is apneic or has a respiratory rate less than 6/min, appears 16 years old or older and appears at least five (5) feet tall in accordance with S-SV Protocol ‘Esophageal Tracheal Airway Device Treatment Guidelines’, Reference No. 877.

2. Use a King Airway device on an unconscious patient with an absent gag reflex, who is apneic or has a respiratory rate less than 6/min, and appears at least four (4) feet tall in accordance with S-SV Protocol ‘King Airway’, Reference No. 1102.

3. Administration of epinephrine by auto-injector or for patients in severe distress for suspected anaphylaxis or asthma in accordance with S-SV Protocol ‘EMT Administration of Epinephrine by Auto-Injector for Suspected Anaphylaxis &/or Severe Asthma”, Reference No. 872.

D. Mutual Aid Response:

1. During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained, certified and accredited according to S-SV EMS policies and procedures.

2. EMTs who are not currently certified in California may temporarily perform their scope of practice in California, when approved by the S-SV EMS Agency Medical Director, in order to provide emergency medical services in response to a request, if all the following conditions are met:

   a. The EMTs are registered by the National Registry of Emergency Medical Technicians or licensed or certified in another state or under the jurisdiction of a branch of the Armed Forces including the Coast Guard of the United States, National Park Service, United States Department of the Interior-Bureau of Land Management, or the United States Forest Service; and

   b. The EMTs restrict their scope of practice to that for which they are licensed or certified.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Optional Skill: Base Hospital Medical Control Requirements, Reference No. 377

EMT Optional Skill: Service Provider Application, Approval Process and Requirements and Responsibilities, Reference No. 477

Continuous Quality Improvement Program (CQIP), Reference No. 620-E

EMT Administration of Epinephrine by Auto-Injector for Suspected Anaphylaxis &/or Severe Asthma, Reference No. 872

Esophageal Tracheal Airway Device Treatment Guidelines, Reference No. 877

Nerve Agent Treatment, Reference No. E-8

King Airway, Reference No. 1102

EMT Certification and Recertification, Reference No. 901

Advanced Airway Management, Reference No. 1104
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SUBJECT: PARAMEDIC SCOPE OF PRACTICE

PURPOSE:

To define the scope of practice of a paramedic accredited in the S-SV EMS region.

AUTHORITY:

California Health & Safety Code, Division 2.5, Sections 1797.84, 1797.172, 1797.220.

California Code of Regulations, Title 22, Division 9, Chapter 4, Section 10046 & 100147

PRINCIPLES:

A. A paramedic may perform any activity identified in the scope of practice of an EMT as specified in S-SV EMS Agency EMT Scope of Practice Policy (Reference No. 801), or any activity identified in the scope of practice of an Advanced EMT as specified in S-SV EMS Agency AEMT Scope of Practice Policy (Reference No. 802).

B. A paramedic shall be licensed in the State of California, accredited by the S-SV EMS Agency, and sponsored by an S-SV EMS Agency approved paramedic prehospital service provider agency in order to perform the approved paramedic scope of practice.

C. Advanced life support activities carried out by paramedics at the scene of a medical emergency or during transport shall be under the following conditions only:

1. Patient care based on S-SV EMS Agency approved policy/protocol (standing orders) without on-line medical control.

2. On-line medical direction by a base/modified base hospital physician or base hospital MICN.

3. Base/modified base hospital contact is required by all paramedics to perform the procedure(s) and/or administer medications(s) that are identified in S-SV EMS Agency policies/protocols as base hospital order only or base/modified base hospital physician order only.
4. Direct medical supervision as outlined in the S-SV EMS Agency ‘Physician on Scene’ policy (Reference No. 839).

5. Interfacility transport written orders from transferring physician as outlined in the S-SV EMS Agency ‘Medical Control for Transfers Between Acute Care Facilities’ policy (Reference No. 840).

6. Procedures outlined in the S-SV EMS Agency ‘Communication Failure’ policy (Reference No. 890) when unable to establish and/or maintain base/modified base hospital communications.

POLICY:

A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to Section 1797.195 of the Health and Safety Code, may perform the following procedures or administer the following medications approved by the S-SV EMS Agency Medical Director:

BASIC SCOPE OF PRACTICE:

A. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).
B. Perform defibrillation, synchronized cardioversion, and external cardiac pacing.
C. Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with Magill forceps.
D. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, periligyngeal airways, stomal intubation, and adult oral endotracheal intubation.
E. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP).
F. Institute intravenous (IV) catheters, saline locks, needles, or other cannula (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.
G. Institute intraosseous (IO needles or catheters).
H. Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
I. Obtain venous blood samples.
J. Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).
K. Utilize Valsalva maneuver.  
L. Perform percutaneous needle cricothyroidotomy.  
M. Perform needle thoracostomy.  
N. Monitor thoracostomy tubes.  
O. Monitor and adjust IV solutions containing potassium ≤ 40 mEq/L.  
P. Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.  
Q. Administer, using prepackaged products when available, the following medications:
   1. 10%, 25% and 50% dextrose;  
   2. activated charcoal;  
   3. adenosine;  
   4. aerosolized or nebulized beta-2 specific bronchodilators – albuterol;  
   5. amiodarone;  
   6. aspirin;  
   7. atropine sulfate;  
   8. calcium chloride;  
   9. diphenhydramine hydrochloride;  
  10. dopamine hydrochloride;  
  11. epinephrine;  
  12. glucagon;  
  13. midazolam;  
  14. lidocaine hydrochloride;  
  15. magnesium sulfate;  
  16. morphine sulfate;  
  17. naloxone hydrochloride;  
  18. nitroglycerin preparations, except intravenous;  
  19. ondansetron;  
  20. pralidoxime chloride;  
  21. sodium bicarbonate.

LOCAL OPTIONAL SCOPE OF PRACTICE:

All licensed and accredited paramedics or supervised paramedic students in the S-SV EMS Region may perform the following additional activities in the prehospital setting and/or during interfacility transport:

A. Adult nasotracheal intubation  
B. Pediatric oral endotracheal intubation

EXPANDED SCOPE OF PRACTICE FOR PARAMEDIC INTERFACILITY TRANSPORT:

A. Only paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director and employed by an ALS Ambulance provider approved for paramedic transport of interfacility transport optional skills
SUBJECT: PARAMEDIC SCOPE OF PRACTICE

by the S-SV EMS Agency Medical Director will be permitted to provide the service of using or monitoring the following during interfacility transports:

1. Automatic Transport Ventilators (ATV’s)
2. Preexisting intravenous infusion of magnesium sulfate, nitroglycerin, heparin &/or amiodarone

B. In addition to the approved paramedic scope of practice, the Critical Care Paramedic (CCP) may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports, when a licensed and accredited paramedic has completed a Critical Care Paramedic (CCP) training program as specified in S-SV EMS Agency ‘Paramedic Training Program Requirements and Approval Process’ policy (Reference No. 1005) and successfully completed competency testing, holds a current certification as a CCP from the Board of Critical Care Transport Certification (BCCTPC), and is employed by an S-SV EMS Agency approved CCP prehospital service provider agency.

1. Set up and maintain thoracic drainage systems;
2. Set up and maintain mechanical ventilators;
3. Set up and maintain IV fluid delivery pumps and devices;
4. Blood and blood products;
5. Glycoprotein IIB/IIIA inhibitors;
6. Heparin IV;
7. Nitroglycerin IV;
8. Norepinephrine;
9. Thrombolytic agents;
10. Maintain total parenteral nutrition;

CROSS REFERENCES:

Policy and Procedure Manual

Paramedic Accreditation to Practice, Reference No. 913

Paramedic Training Program Requirements and Approval Process, Reference No. 1005.

Paramedic Interfacility Transport Optional Skills: Service Provider Requirements and Responsibilities, Reference No. 441
SUBJECT: MULTIPLE CASUALTY INCIDENTS (MCI)

INTRODUCTION:

The Sierra-Sacramento Valley Emergency Medical Services Agency serves a multi-county area in California Governor’s Office of Emergency Services (OES) Regions III and IV. EMS personnel must be prepared to quickly shift from a 1-on-1 patient/provider relationship to a multiple patient incident operation. This may include the routine 2-5 patient incidents through the multiple/mass casualty incidents. EMS personnel must be prepared to implement and function within the Standardized Emergency Management System (SEMS), National Incident Management System (NIMS), and Multiple Casualty Incident (MCI)/Incident Command System (ICS).

PURPOSE:

To direct EMS responders regarding the response organization, personnel, equipment, resources, and procedures for field operations during a multiple casualty incident. This policy is intended to supplement the California OES Region III and Region IV MCI Plans.

AUTHORITY:

Health & Safety Code, Division 2.5, Sections 1797.218, 1797.220.

California Code of Regulations, Title 22, Division 9, (Sections 100127, 100128, 100167, 100168, 100170).

California Code of Regulations, Title 19, Division 2, Articles 1-8, Sections 2400 et seq., Standardized Emergency Management System (SEMS) Regulations.

DEFINITIONS:

A. **Multi-Casualty Incident (MCI)** is an incident which requires more emergency medical resources to adequately deal with the victims than those available during routine responses.

B. **Control Facility (CF)** is the facility responsible for the dispersal of all patients during Multi-Casualty Incidents. The designated Control Facilities for the S-SV EMS Region are listed in Policy Reference No. 505-A ‘Hospital Capabilities’.
POLICY:

A. The California OES Region III and Region IV MCI Plan’s shall be used as a standard for training and managing MCIs within the S-SV EMS Region.

B. During an MCI all S-SV EMS Agency policies and procedures for treatment, destination, etc apply. The CF shall consider trauma triage criteria before directing the transport of trauma patients. Immediate trauma patients shall be transported to designated trauma centers until the trauma centers are unable to accept further trauma patients.

C. Emergency response agencies and personnel shall familiarize themselves with the Standardized Emergency Management System (SEMS) Regulations.

D. EMS personnel shall apply Incident Command System (ICS) concepts routinely on all emergency responses so that shifting from 1-on-1 patient/provider relationship to a multiple patient incident will occur without difficulty.

E. Provider agencies shall be responsible for the training of their personnel in the above.

PROCEDURE

Activation of the Multi-Casualty Incident System consists of the mobilization of the necessary resources, notification of the CF, and initiation of ICS.

A. As soon as it is determined that an emergency call may prove to be an MCI, additional appropriate resource requests and CF notifications should occur.

B. The procedures listed in the ‘MCI – Response Procedures’ addendum, Reference No. 837-A shall be followed, and the CF shall be utilized when one or more of the following criteria are met:

1. Five (5) or more Immediate and/or Delayed patients from a unifocal incident, or
2. Ten (10) or more Minor patients from a unifocal incident, irrespective of the number of Immediate and/or Delayed patients, or
3. At the discretion of the EMS provider(s) on scene or the base/modified base hospital.
INCIDENT NOTIFICATION AND REVIEW:

A. Prehospital ground transport provider supervisory/management representatives shall notify the S-SV EMS Agency Executive Director or Duty Officer as soon as possible of any declared MCI in the S-SV EMS region. The Agency Executive Director or Duty Officer shall also be provided with appropriate and timely incident updates (including notification if the incident is having an adverse impact on the remainder of the local EMS system).

B. EMS provider agencies shall conduct an after action review of all MCI incidents, to include appropriate prehospital and CF representatives at a minimum, as soon as possible after the conclusion of the incident. The purpose of this after action review will be to identify any immediate issues, recognition, or areas for improvement.

C. MCI Critique Forms shall be completed and submitted to the S-SV EMS Agency as indicated below for any declared MCI:

1. Prehospital ground transport providers shall complete and submit to the S-SV EMS Agency the ‘Prehospital MCI Critique Form’ (Reference No. 837-D) within seven (7) working days. The completion and submission of this form is optional for prehospital non-transport and/or air transport providers.

2. The Control Facility for the incident shall complete and submit to the S-SV EMS Agency the ‘Control Facility MCI Critique Form’ (Reference No. 837-E) within seven (7) working days.

3. The ‘Receiving Facility MCI Critique Form’ (Reference No. 837-F) shall be completed and submitted to the S-SV EMS Agency by any facility receiving patients from the incident.

D. The S-SV EMS Agency will determine if any additional action is necessary based on a review of the incident documentation and any discussion or requests from EMS system participants involved in the incident.

CROSS REFERENCES:

Policy and Procedure Manual

Patient Destination, Reference No. 505

S-SV EMS Region Hospital Capabilities, Reference No. 505-A

Base Hospital/Modified Base Hospital Contact, Reference No. 812
SUBJECT: MULTIPLE CASUALTY INCIDENTS (MCI)

Medical Control at the Scene of an Emergency, Reference No. 835

MCI – Response Procedures, Reference No. 837-A

MCI – ICS Medical Branch Organizational Structure, Reference No. 837-B

MCI – Position Responsibilities, Reference No. 837-C

Prehospital MCI Critique Form, Reference No. 837-D

Control Facility MCI Critique Form, Reference No. 837-E

Receiving Facility MCI Critique Form, Reference No. 837-F

Crisis Standard of Care Procedures, Reference No 838
# SUBJECT: MCI – RESPONSE PROCEDURES

<table>
<thead>
<tr>
<th>Activation Triggers</th>
<th>Incident conditions significantly impact or overwhelm hospital or prehospital resources, which may include one or more of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Five (5) or more Immediate and/or Delayed patients from a unifocal incident, or</td>
</tr>
<tr>
<td></td>
<td>• Ten (10) or more Minor patients from a unifocal incident, irrespective of the numbers of Immediate and/or Delayed patients, or</td>
</tr>
<tr>
<td></td>
<td>• At the discretion of the EMS provider(s) on scene or the base/modified base hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Command &amp; Control</th>
<th>A. The Incident Commander (IC) shall be the individual present on scene representing the public service agency having primary investigatory authority or responsibility. This role may be delegated to another appropriate public safety representative (i.e. Fire Department) if necessary, or a unified command may be established based on the needs of the incident.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. The IC may directly supervise operations or appoint an Operations Section Chief.</td>
</tr>
<tr>
<td></td>
<td>C. The first-in medical responders should be appointed Medical Group Supervisor (MGS) and Triage Unit Leader.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Responders</th>
<th>A. The first medical unit enroute shall notify the appropriate Control Facility (CF) of a possible MCI. Once on scene, report to the IC and get permission to establish the medical group (or temporarily assume IC and establish the ICS), including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>Resources</strong>: Ensure adequate resources have been ordered (Equipment, Manpower, Transportation), and clarify with the IC the ordering process (i.e. can MGS order additional medical resources). Update dispatch as appropriate, and the Control Facility as soon as possible upon arrival.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Assignments</strong>: Assign Triage Unit Leader to begin triage.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Communications</strong>: Dispatch will assign frequencies (i.e. tactical, command, air operations) for the incident. Clarify with the IC if necessary.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Ingress/Egress</strong>: Determine the best routes in and out of the incident in cooperation with the IC, and notify dispatch if appropriate.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Name</strong>: Incident name will normally be assigned by dispatch. Clarify incident name with the IC if necessary.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Geography</strong>: Quickly determine with the IC where staging, triage, treatment and transport areas will be established.</td>
</tr>
<tr>
<td></td>
<td>B. The first-in ambulance should generally be the last ambulance to leave the scene. Medical supplies from the first-in ambulance should be used on scene by the triage and treatment units.</td>
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</tbody>
</table>
### Subject: MCI – Response Procedures

#### Triage

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A.</td>
<td>S.T.A.R.T. triage shall be used. Triage tags shall be applied to each patient.</td>
</tr>
<tr>
<td>B.</td>
<td>Personnel should spend no more than 30-60 seconds per patient triaging.</td>
</tr>
<tr>
<td>C.</td>
<td>Treatment rendered will initially be confined to airway positioning and major hemorrhage control.</td>
</tr>
<tr>
<td>D.</td>
<td>CPR shall not be initiated on cardiac arrest victims unless it is consistent with S-SV EMS policy (i.e. – patient does not meet criteria for obvious death or probable death), and there are sufficient personnel on scene to not result in the detriment of care to other patients.</td>
</tr>
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</table>

#### Treatment

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>A.</td>
<td>Designate Treatment Areas as needed: Immediate (Red), Delayed (Yellow), and Minor (Green). These areas should be located in safe areas, large enough to handle the number of victims, easily accessible to patient transport vehicles, and away from the Morgue Area (Black).</td>
</tr>
<tr>
<td>B.</td>
<td>Once initial triage has been completed, patients may be sent to the appropriate treatment area. Continuous re-triage and patient evaluation should occur in these areas until the patient is transported.</td>
</tr>
<tr>
<td>C.</td>
<td>Personnel assigned to the treatment areas shall only function within their scope of practice.</td>
</tr>
<tr>
<td>D.</td>
<td>Any on-scene MD’s and RN’s should be assigned to the treatment areas.</td>
</tr>
</tbody>
</table>

#### Transportation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>If a staging area has been established, transport crews shall remain with their vehicle in the staging area until requested to the scene.</td>
</tr>
<tr>
<td>B.</td>
<td>The Patient Transportation Unit Leader (or Medical Communications Coordinator if established), in cooperation with the CF will arrange transport of patients to the most appropriate facilities.</td>
</tr>
<tr>
<td>C.</td>
<td>At all times the most immediate patients should be transported first to the most appropriate available medical facility as directed by the CF.</td>
</tr>
<tr>
<td>D.</td>
<td>Patients may be transported by a lower level of trained personnel as determined by the Patient Transportation Unit Leader in cooperation with Treatment Area Managers based on available resources and personnel.</td>
</tr>
<tr>
<td>E.</td>
<td>The Patient Transportation Unit Leader (or Medical Communications Coordinator if established) will contact the CF and provide patient information, and total number of transport resources available. Patient information will be limited to age, gender, triage category, triage tag number, and major injury.</td>
</tr>
<tr>
<td>F.</td>
<td>The CF will relay patient information to the receiving facilities.</td>
</tr>
<tr>
<td>G.</td>
<td>Non-traditional transport resources (e.g. buses, vans) may be used on large scale incidents when appropriate as directed by the CF. Appropriate EMS personnel must accompany patients transported by these non-traditional transport resources.</td>
</tr>
</tbody>
</table>
### Communications

A. On-scene coordination/car-to-car communications may occur on an assigned EMS Tactical Channel.

B. All additional resources shall be requested through the IC (or Logistics Section if established). However, if authorized by the IC, the MGS may request ambulance resources directly through the appropriate Ambulance Dispatch and notify the IC or designee.

C. The Control Facility shall be notified:
   - Enroute by the first-in ambulance to a known or suspected MCI,
   - After initial scene size-up, and after triage is completed,
   - When patients are ready for transport (to obtain destinations),
   - When units depart the scene (with Unit #/ETA), and
   - When the scene is clear and there are no further patients to be transported.

### Documentation

A. Triage tags shall be used, followed by a Patient Care Report (PCR) for each patient.

B. The PCR requirement may be waived by the S-SV EMS Agency on large scale incidents.

C. The Patient Transportation Worksheet shall be completed by the Patient Transportation Unit Leader.

D. The MGS shall complete the Medical Branch Worksheet if necessary.

E. The Ambulance Staging Log shall be completed by the Ambulance Coordinator if necessary.

F. ICS 214 logs shall be completed by each position as requested by the IC or their designee.

G. The MGS is responsible to ensure all paperwork is complete, in coordination with the CF as necessary.
• The number and type of positions filled is based on the size of the incident. Smaller incidents may only require a Triage Unit Leader, and a Medical Group Supervisor who also performs the functions of Treatment Unit Leader and Patient Transportation Unit Leader.

• Positions should be filled based on the individual’s qualifications to adequately perform the assigned function.
# SUBJECT: MCI – POSITION RESPONSIBILITIES

## MEDICAL GROUP SUPERVISOR (MGS)
- **Resources**: assess need for additional resources:
  - Equipment: medical supplies (e.g. medical caches, backboards, litters, cots).
  - Manpower: FRs, EMTs, paramedics.
  - Transportation: air/ground, vans, buses.
- **Assignments**:
  - Establish Medical Group, assign personnel.
  - Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, ambulance, etc.
- **Communications**:
  - Participate in Medical Branch/Operations Section planning activities.
  - Ensure notification of the Control Facility.
- **Ingress/Egress**: Report staging area and transport routes to dispatch.
- **Name**: Confer with IC/Ops Chief to determine incident name, report to dispatch / Control Facility.
- **Geography**: Designate Treatment Area locations.
  - Isolate Morgue and Minor Treatment Area from Immediate/ Delayed Treatment Areas.
  - Request proper security, traffic control, and access for the Medical Group work areas.
- **Maintain Unit/Activity Log (ICS Form 214)**.

## TREATMENT UNIT LEADER
- Develop organization sufficient to handle assignment.
- Inform Medical Group Supervisor of resource needs.
- Implement triage process.
  - Ensure triage tags are properly applied to each victim.
- Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
- Give periodic status reports to Medical Group Supervisor, including total victim counts by triage category.
- Maintain security and control of the Triage Area.
- Establish Morgue.
- **Maintain Unit/Activity Log (ICS Form 214)**.

## PATIENT TRANSPORTATION UNIT LEADER
- Ensure the establishment of communications with the Control Facility.
- Designate Ambulance Staging Area(s).
- Direct patient destinations as reported by the Medical Communications Coordinator and Control Facility.
- Ensure patient information and destinations are recorded on the Patient Transport Worksheet.
- Establish communications with the Ambulance Coordinator.
- Request additional ambulances as required.
- Notify Ambulance Coordinator of ambulance requests.
- Coordinate requests for air ambulance transportation through the Air Operations Branch Director.
- Coordinate the establishment of the Air Ambulance Helispots with the Medical Branch Director and Air Operations Branch Director (if assigned).
- **Maintain Unit/Activity Log (ICS Form 214)**.
## MEDICAL BRANCH DIRECTOR
The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident.

- Review Group Assignments for effectiveness of current operations and modify as needed.
- Provide input to Operations Section Chief for the Incident Action Plan.
- Supervise Branch activities.
- Report to Operations Section Chief on Branch activities.
- Maintain Unit/Activity Log (ICS Form 214).

## TREATMENT AREA MANAGER
- Request or establish Medical Teams as necessary.
- Assign treatment personnel to patients received in the Treatment Area.
- Ensure treatment of patients triaged to the Treatment Area.
- Assure that patients are prioritized for transportation.
- Coordinate transportation of patients with Treatment Dispatch Manager.
- Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
- Ensure that appropriate patient information is recorded.
- Maintain Unit/Activity Log (ICS Form 214)

## MEDICAL COMMUNICATIONS COORDINATOR
- Establish communications with the Control Facility.
- Determine and maintain current status of hospital/medical facility availability and capability.
- Receive basic patient information and condition from Treatment Dispatch Manager.
- Coordinate patient destination with the hospital alert system.
- Communicate patient transportation needs to Ambulance Coordinator based upon requests from Treatment Dispatch Manager.
- Communicate patient air ambulance transportation needs to the Air Operations Branch Director based on requests from the Treatment Area Manager(s) or Treatment Dispatch Manager.
- Maintain Patient Transport Worksheet.
- Maintain Unit/Activity Log (ICS Form 214)

## AMBULANCE COORDINATOR
- Establish appropriate staging area for ambulances.
- Establish routes of travel for ambulances for incident operations.
- Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation assignments.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Provide ambulances upon request from the Medical Communications Coordinator.
- Assure that necessary equipment is available in the ambulance for patient needs during transportation.
- Establish contact with ambulance providers at the scene.
- Request additional transportation resources as appropriate.
- Provide an inventory of medical supplies available at ambulance staging area for use at the scene.
- Maintain records as required and Unit/Activity Log (ICS Form 214)
## SUBJECT: MCI – POSITION RESPONSIBILITIES

<table>
<thead>
<tr>
<th>MEDICAL SUPPLY COORDINATOR</th>
<th>TREATMENT DISPATCH MANAGER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acquire, distribute and maintain status inventory of medical equipment and supplies within the Medical Group*.</td>
<td>• Establish communications with the Immediate, Delayed, and Minor Treatment Managers.</td>
</tr>
<tr>
<td>• Request additional medical supplies*</td>
<td>• Establish communications with the Patient Transportation Unit Leader.</td>
</tr>
<tr>
<td>• Distribute medical supplies to Treatment and Triage Units.</td>
<td>• Verify that patients are prioritized for transportation.</td>
</tr>
<tr>
<td>• Maintain Unit/Activity Log (ICS Form 214).</td>
<td>• Coordinate transportation of patients with Medical Communications Coordinator.</td>
</tr>
<tr>
<td>*If the Logistics Section is established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.</td>
<td>• Assure that appropriate patient tracking information is recorded.</td>
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<table>
<thead>
<tr>
<th>MORGUE MANAGER</th>
<th>TREATMENT DISPATCH MANAGER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess resource/supply needs and order as needed.</td>
<td>• Coordinate ambulance loading with the Treatment Managers and ambulance personnel.</td>
</tr>
<tr>
<td>• Coordinate all Morgue Area activities.</td>
<td>• Maintain Unit/Activity Log (ICS Form 214).</td>
</tr>
<tr>
<td>• Keep area off limits to all but authorized personnel.</td>
<td></td>
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</tbody>
</table>
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Prehospital Provider MCI Critique Form (Policy Addendum 837-D)

Please Complete Following All MCI’s And Full Scale Exercises

Send Completed Forms to the S-SV EMS Agency
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Reporting Entity Information:

<table>
<thead>
<tr>
<th>Prehospital provider agency:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Name/title of person completing this form:</th>
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<table>
<thead>
<tr>
<th>Phone number:</th>
<th>Email address:</th>
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</table>

Incident Information: □ Real Event □ Drill

<table>
<thead>
<tr>
<th>County: □ Colusa □ Butte □ Nevada □ Placer □ Shasta □ Siskiyou □ Sutter □ Tehama □ Yuba</th>
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<thead>
<tr>
<th>Incident date:</th>
<th>Incident start time:</th>
<th>Incident end time:</th>
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<table>
<thead>
<tr>
<th>Incident name:</th>
<th>Incident location:</th>
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</table>

<table>
<thead>
<tr>
<th>Incident Commander (Name &amp; Agency):</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Medical Group Supervisor (Name &amp; Agency):</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Triage Unit Leader (Name &amp; Agency):</th>
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</table>

<table>
<thead>
<tr>
<th>Treatment Unit Leader (Name &amp; Agency):</th>
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</table>

<table>
<thead>
<tr>
<th>Patient Transportation Unit Leader (Name &amp; Agency):</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Were triage tags used?</th>
<th>□ Yes □ No</th>
<th>Were MCI ID vests worn?</th>
<th>□ Yes □ No</th>
</tr>
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<tbody>
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</table>

Number and Type of Patients

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<thead>
<tr>
<th>Immediate:</th>
<th>Delayed:</th>
<th>Minor:</th>
<th>Refused:</th>
<th>Deceased:</th>
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<tbody>
<tr>
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</table>

Number and Type of Transport Resources

<table>
<thead>
<tr>
<th>Ground ambulance:</th>
<th>Air ambulance/rescue:</th>
<th>Bus/other:</th>
</tr>
</thead>
<tbody>
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First responder agencies utilized:

<table>
<thead>
<tr>
<th>Ground transport agencies utilized:</th>
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<tbody>
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</tbody>
</table>

Air transport agencies utilized:

Control Facility (CF) Utilization/Interaction:

<table>
<thead>
<tr>
<th>Name of CF utilized for patient dispersal:</th>
</tr>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CF pre-alert by dispatch or prehospital personnel:</th>
<th>□ Yes □ No</th>
<th>Notification time:</th>
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<table>
<thead>
<tr>
<th>CF notification by on scene prehospital personnel:</th>
<th>□ Yes □ No</th>
<th>Notification time:</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Were patient destinations received in a reasonable timeframe:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Prehospital Provider MCI Critique Form (Policy Addendum 837-D)
Please Complete Following All MCI’s And Full Scale Exercises
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After Action Review Information:

<table>
<thead>
<tr>
<th>Was an After Action Review completed:</th>
<th>Yes</th>
<th>No</th>
<th>AAR date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all agencies involved in the AAR:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments, Issues, Suggestions, and Observations (attach additional documentation if necessary):

(837-D) Updated 02-2013
Control Facility (CF) MCI Critique Form (Policy Addendum 837-E)

Please Complete Following All MCI’s And Full Scale Exercises

Send Completed Forms to the S-SV EMS Agency

Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Reporting Entity Information:

Name of Control Facility (CF):

Name/title of person completing this form:

Phone number: __________________________ Email address: __________________________

Incident Information:    □ Real Event    □ Drill

County: □ Colusa □ Butte □ Nevada □ Placer □ Shasta □ Siskiyou □ Sutter □ Tehama □ Yuba

Incident date: __________________________ Incident time: __________________________ Incident name: __________________________

Incident location: __________________________

Number of CF staff dedicated to running the MCI:

CF staff names:

Initial “MCI Alert” received from: __________________________ Initial alert time: __________________________

Issues with “MCI Alert”:

On scene/field contact (Name & Agency):

Was Patient Transportation Unit Leader clearly identified? □ Yes □ No

Issues with field contact communication:

Polling completed by: □ EMResource □ Blast Phone □ Other:

Issues with polling:

Number and Type of Patients

<table>
<thead>
<tr>
<th>Immediate</th>
<th>Delayed</th>
<th>Minor</th>
<th>Refused</th>
<th>Deceased</th>
</tr>
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</table>

Was the scene cleared? □ Yes □ No    Time scene cleared: __________________________
Please Complete Following All MCI’s And Full Scale Exercises

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Comments, Issues, Suggestions, and Observations (attach additional documentation if necessary):
Receiving Facility MCI Critique Form (Policy Addendum 837-F)

Please Complete Following MCI’s And Full Scale Exercises

Send Completed Forms to the S-SV EMS Agency

Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Reporting Entity Information:

Name of receiving facility:

Name/title of person completing this form:

Phone number: Email address:

Incident Information: ☐ Real Event  ☐ Drill

County: ☐ Colusa ☐ Butte ☐ Nevada ☐ Placer ☐ Shasta ☐ Siskiyou ☐ Sutter ☐ Tehama ☐ Yuba

Incident date: Incident time: Incident name:

Initial “MCI Alert” received from: Initial alert time:

Were you given enough information concerning the MCI? ☐ Yes ☐ No

Issues with the “MCI Alert”:

Did the Control Facility (CF) provide adequate updates about the MCI? ☐ Yes ☐ No

Were you given the following information about your patients?

Transport unit: ☐ Yes ☐ No  ETA: ☐ Yes ☐ No  Injury/illness: ☐ Yes ☐ No

Were patient conditions consistent with triage category? ☐ Yes ☐ No

Comments, Issues, Suggestions, and Observations (attach additional documentation if necessary):

(837-F) Updated 02-2013
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SUBJECT: CRISIS STANDARD OF CARE PROCEDURES

PURPOSE:

To provide a mechanism to alter the EMS delivery system in response to an unusual increased demand for emergency medical aid services beyond the capacity of the current system providers.

AUTHORITY:

Health and Safety Code, Article 1, Section 101040

Health and Safety Code, Division 2.5, Section 1797.172

California Code of Regulations, Title 13, Division 2, Ch. 5, Art. 1, Section 1100.3

California Code of Regulations, Title 22, Division 9:

- Chapter 2, Section 10062, 10063 & 10064 – EMT
- Chapter 3, Section 100106 & 100106.1 – Advanced EMT
- Chapter 4, Section 100144 & 100145 – Paramedic

California Vehicle Code, Division 2.5, Chapter 2.5, Article 2, Section 2512

DEFINITIONS:

Crisis Standard of Care – A level of medical care delivered to individuals under conditions of duress, such as after a disaster, or when medical resources are insufficient for demand for emergency care

Medical/Health Operational Area Coordinator (MHOAC) – The Public Health Officer and local EMS Agency Administrator or designee who is responsible, in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) border. The MHOAC role is shared between the S-SV EMS Agency and the Public Health Officer in some counties, and assumed by the Health Officer alone in other counties (Medical & Health Disaster Responsibilities Reference No. 838-D)
SUBJECT: CRISIS STANDARD OF CARE PROCEDURES

OA EOC – The Operational Area Emergency Operations Center for any of the member counties within the Sierra-Sacramento Valley EMS Agency Region

QRV – A Quick Response Vehicle that is staffed with at least one Advanced EMT (AEMT) or Paramedic and equipped with advanced life support (ALS) equipment/supplies per S-SV EMS Agency policy

ASSUMPTIONS:

A. The Medical/Health Branch of the OA EOC or MHOAC has established collaboration with the S-SV EMS Agency Medical Director and other affected agencies to coordinate EMS system response changes.

B. Mutual-aid resources are scarce or unavailable.

C. Appropriate waivers, proclamations, or declarations required to implement specific system changes have been identified and secured.

PROCEDURE:

A. MHOAC and S-SV EMS Agency Collaboration:

1. During a significant incident, and prior to a locally declared emergency, the S-SV EMS Agency Medical Director should collaborate with the affected County Public Health Officer, Office of Emergency Services, and other appropriate agencies to modify the EMS delivery system in order to meet increased demand on the EMS system.

2. During a locally declared emergency, the MHOAC or Medical/Health Branch Director of the OA EOC should collaborate with the S-SV EMS Agency Medical Director, and other appropriate agencies, to modify the EMS delivery system in order to meet increased demand on the EMS system.

B. System Access:

1. The MHOAC and S-SV EMS Agency should collaborate with the OA EOC to establish priorities for 911 medical-aid response based upon available system resources.

2. The MHOAC and S-SV EMS Agency should collaborate to complete the Crisis Standard of Care Orders (Reference No 838-B) to ensure the stability of the EMS system, and inform all Public Safety Answering Points (PSAPs), ambulance dispatch centers, control facilities, hospitals, and EMS providers of these orders.

3. The MHOAC and S-SV EMS Agency should collaborate to ensure notification of all provider agencies in the event that a Public Access
telephone number (e.g. 211) or web based information for the public seeking minor medical care, social services, and other non-emergent needs has been established by the OA EOC or Public Health Department.

4. The OA EOC in cooperation with the MHOAC and S-SV EMS Agency should consider establishing Field Treatment Sites for rapid triage, treatment, and referral.

5. The MHOAC and S-SV EMS Agency should collaborate to authorize altered triage and response protocols for the 911 system, including consideration of the following:
   a. Suspension of Pre-Arrival Instructions
   b. Implementation of symptom-specific triage (e.g. Pandemic Outbreak Emergency Medical Dispatch)
   c. Implementation of Altered 911/EMD Triage Algorithm (Reference No. 838-A)

6. The OA EOC, in cooperation with the MHOAC and S-SV EMS Agency should consider establishing a Scheduled Transport Center for all medical transport requests from all System Access Points (i.e. hospitals, health facilities, Public Access Number, 911, and field), including consideration of the following:
   a. Augmenting medical transportation with alternative vehicles (buses, taxis, etc.)
   b. Developing and implementing a medical transportation scheduling process.
   c. Working with S-SV EMS Agency designated control facilities to direct destinations of transport resources, including possible Alternate Care Sites, clinics, etc.

C. Field Response:

1. The OA EOC in cooperation with the MHOAC and S-SV EMS Agency should consider:
   a. Establishing EMS Muster Stations to consolidate personnel, equipment, supplies and emergency response vehicles
   b. Expanding available EMS resources by converting all ambulances to BLS transport units (EMT and EMR staffing) and implementing QRVs with available Advanced EMT and Paramedic personnel
SUBJECT: CRISIS STANDARD OF CARE PROCEDURES

- QRVs may consist of agency supervisor vehicles, other company vehicles, shared resources from other emergency response agencies, rental vehicles, private vehicles, etc.

- QRVs will be equipped with appropriate ALS/LALS equipment/supplies, communications equipment, etc.

c. Implementation of Crisis Standard of Care Prehospital Treatment Orders (reference No. 838-C) to establish alternative EMS treatment and transport of patients in the prehospital setting

d. Developing additional disaster caches, as needed, to augment EMS supplies (e.g. Flu Cache of electrolyte replacement fluids, ibuprofen, pepcid, etc.)

e. Developing, equipping and deploying a specialty response team to respond to specific types of patients

2. The OA EOC should work collaboratively with the MHOAC and S-SV EMS Agency to develop a Family/Patient Brochure for distribution by EMS personnel to the public to include the following:

a. Explanation of the current healthcare situation and the Crisis Standard of Care directions currently being implemented

b. Preventive measures to avoid exposure to health threat

c. Available community resources (e.g. public access telephone number, website, etc.)

D. Just-In-Time Training:

The impacted EMS provider agencies in cooperation with the OA EOC and MHOAC and S-SV EMS Agency should develop just-in-time training for prehospital personnel to include:

1. Altered 911/EMD Triage Algorithm (Reference No. 838-A)

2. Crisis Standard of Care EMS System Orders (Reference No. 838-B)

3. Crisis Standard of Care Prehospital Treatment Orders (Reference No. 838-C)

4. Family/Patient Brochure

5. Consideration of other appropriate just-in-time training (e.g. grief support, etc.)
SUBJECT: CRISIS STANDARD OF CARE PROCEDURES

EXAMPLES:

A. Example of Altered 911/EMD Triage:

<table>
<thead>
<tr>
<th>Access Point</th>
<th>Symptom-Specific</th>
<th>Immediate</th>
<th>Delayed</th>
<th>Minor</th>
<th>Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Access #</td>
<td>Refer to (symptom-specific) Alternate Care Site</td>
<td>Refer to 911</td>
<td>Refer to Scheduled Transport Center</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>911/ Ambulance Dispatch</td>
<td>Dispatch Specialty Unit/Team</td>
<td>ALS Response</td>
<td>Refer to Scheduled Transport Center</td>
<td>Refer to Public Access #</td>
<td>Refer to Public Access #</td>
</tr>
<tr>
<td>Scheduled Transport Center</td>
<td>Dispatch Specialty Unit/Team</td>
<td>ALS Response</td>
<td>Schedule Transport</td>
<td>Refer to Public Access #</td>
<td>Refer to Public Access #</td>
</tr>
<tr>
<td>Field EMS</td>
<td>Transport to (symptom-specific) Alternate Care Site</td>
<td>Treat and Transport</td>
<td>Treat &amp; Release or Refer</td>
<td>Refer to Public Access #</td>
<td>Witnessed: shock X3, Unwitnessed: refer to Public Access #</td>
</tr>
</tbody>
</table>

B. Example of Altered EMS System Response:

- All ambulances are staffed with BLS personnel (EMRs and EMTs)
- All Advanced EMT and Paramedic personnel are assigned to QRVs to respond to patients with immediate medical needs (AEMT/Paramedic personnel may be placed on supervisor vehicles, on fire apparatus, or deployed in other non-traditional EMS response vehicles).
- After providing on-scene medical care/intervention, patients are handed off to a BLS transport unit, making the QRV available to respond to the next call in need of ALS intervention
- Other options include: Treat & Release on-scene; referral to Public Access telephone number; referral to Transport Center for scheduled transport to hospital or other medical agency

CROSS REFERENCE:

Policy and Procedure Manual
Crisis Standard of Care Procedures - Altered 911/EMD Triage Algorithm, Reference No. 838-A
Crisis Standard of Care EMS System Orders, Reference No. 838-B
SUBJECT: CRISIS STANDARD OF CARE PROCEDURES

Crisis Standard of Care Prehospital Treatment Orders, Reference No. 838-C

Medical & Health Disaster Responsibilities, Reference No. 838-D
SUBJECT: CRISIS STANDARD OF CARE ALTERED 911/EMD TRIAGE ALGORITHM

Reporting Party  
911 Call Center  
Transfer to Medical Dispatcher  
YES  
Medical Emergency?  
NO  
Refer to Appropriate Resource  
YES  
SOB/Chest Pain? Acute ALOC? Significant Trauma? Severe Bleeding?  
NO  
Can pt. talk?  
YES  
Can pt. walk unassisted?  
YES  
Refer to 211 (or 7-digit) Public Access #  
NO  
NO  
YES  
DISPATCH AEMT/Paramedic Response (QRV)  
Refer to Scheduled Transport Center

Check availability of alternate transportation:
- Family, Friend, or Neighbor
- Public Transit
- Dial-a-Ride
- Taxi
- Flu Bus

If no alternative transportation is available:
- Schedule BLS transport and confirm with call back to patient
This page intentionally left blank
**Effective Date/Time:**  

**End Date/Time:**

<table>
<thead>
<tr>
<th>Affected County/OA</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Butte</td>
</tr>
</tbody>
</table>

**NOTICE**

The following actions should be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All EMS providers, ambulance dispatch centers, and EMS field units should be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

**EMERGENCY ORDERS**

Operating as an agent of the Sierra-Sacramento Valley EMS Agency, I hereby authorize the following Crisis Standard of Care Orders.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date/Time:</td>
</tr>
</tbody>
</table>

### ACTIONS

<table>
<thead>
<tr>
<th>Order #</th>
<th>Initial to Execute</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSO-1</td>
<td>Notify all affected Dispatch Center personnel of CSOs</td>
<td></td>
</tr>
<tr>
<td>CSO-2</td>
<td>Notify All affected EMS Field Units and personnel of CSOs</td>
<td></td>
</tr>
</tbody>
</table>
| CSO-3   | **Conduct an EMS System Resource Roll Call – Determine Status and Welfare**  
Conduct an EMS system resource roll call to determine status and welfare of logged-on units. Contact each unit to determine status and ability to respond. This may be used following a natural or man-made disaster (earthquake, flash flood, hazardous materials event, terrorist event, etc.), when ambulance resources may have been compromised. |
| CSO-4   | **Place All Available Ambulances in Service**  
Place all available ambulances in service. Notify each private ambulance dispatch center to place all available units into service and immediately make them available for 9-1-1 system response. Dispatchers shall attach BLS ambulances to any appropriate event. Once attached to an event, a BLS unit should not be canceled because of ALS availability. |
| CSO-5   | **Dispatch BLS to Alpha, Bravo, and Code 2 EMS Events**  
Once attached to an event, the BLS ambulance should remain on the event even if the call is upgraded. If ALS is required, the first responder agency should provide this service (if available) and follow up to the hospital if needed. |
| CSO-6   | **Automatic Ambulance Dispatches are Suspended Until Verified by First Responder**  
Ambulances should only be sent to calls for services when a patient has been identified and is in need of EMERGENCY transportation by ambulance. Patients not in immediate need will not be transported. |
| CSO-7   | **Ambulance Dispatches to Alpha, Bravo, and Code 2 EMS Calls are Suspended** |
| CSO-8   | Implement Pandemic EMD Triage Card |
| CSO-9   | PSAPs may Discontinue Use of Emergency Medical Dispatching (EMD) Procedures  
Implement Altered Triage Algorithm |
<p>| CSO-10  | PSAPs may Discontinue Use of Pre-Arrival Instructions (PAI) |
| CSO-11  | Authorize use of non-traditional transport (e.g. buses, taxis, etc.) |</p>
<table>
<thead>
<tr>
<th>Order #</th>
<th>Initial to Execute</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSO-10</td>
<td></td>
<td>Authorize use of non-traditional transport (e.g. buses, taxis, etc.)</td>
</tr>
<tr>
<td>CSO-11</td>
<td></td>
<td>Notify All Hospitals of CSOs</td>
</tr>
<tr>
<td>CSO-12</td>
<td></td>
<td>Suspend System Communications on ______________________ radio frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notify all hospitals that use of the ______________________ radio frequency is suspended and allocated for EMS Command Net communications.</td>
</tr>
<tr>
<td>CSO-13</td>
<td></td>
<td>Direct all Ambulance Patient Destinations</td>
</tr>
<tr>
<td>CSO-14</td>
<td></td>
<td>All Hospitals Ordered Open</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notify hospitals that diversion and trauma bypass statuses are suspended.</td>
</tr>
<tr>
<td>CSO-15</td>
<td></td>
<td>Ambulance High System Volume Actions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement or continue high system volume management plans.</td>
</tr>
<tr>
<td>CSO-16</td>
<td></td>
<td>Alert EMS Command Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alert all EMS Command Staff (managers, supervisors) and advise to monitor EMS Command Net Communications on frequency:</td>
</tr>
<tr>
<td>CSO-17</td>
<td></td>
<td>Activity Suspension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Announce to field units that the following activities have been suspended until further notice:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ off-duty times (e.g. vacations, PTO, etc), ☐ meal breaks, ☐ inter-facility transports.</td>
</tr>
<tr>
<td>CSO-18</td>
<td></td>
<td>Ambulances Should Transport to the Closest Open Emergency Department</td>
</tr>
<tr>
<td>CSO-19</td>
<td></td>
<td>Replace PCRs with Triage Tags</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discontinue all Patient Care Reports (PCRs) and replace with Triage Tags. Only basic patient information and triage status is collected.</td>
</tr>
<tr>
<td>CSO-20</td>
<td></td>
<td>Move All Ambulances to Muster Stations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All available ambulances (ALS and BLS) shall be staged at the following muster locations:</td>
</tr>
<tr>
<td></td>
<td>RESOURCE</td>
<td>LOCATION</td>
</tr>
<tr>
<td></td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#3</td>
<td></td>
</tr>
<tr>
<td>CSO-21</td>
<td></td>
<td>Deploy Pandemic Response Team</td>
</tr>
</tbody>
</table>

**Additions/Notes:**

Discontinue the Following Orders:

| Total Number of Actions to Execute | Total Number of Actions to Discontinue |
Effective Date/Time: | End Date/Time:
---|---

Affected County/OA
- [ ] Butte
- [ ] Colusa
- [ ] Nevada
- [ ] Placer
- [ ] Shasta
- [ ] Siskiyou
- [ ] Sutter
- [ ] Tehama
- [ ] Yuba

**NOTICE**
The following orders should be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All EMS providers should be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

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**EMERGENCY ORDERS**
Operating as an agent of the Sierra-Sacramento Valley EMS Agency Medical Director, I hereby authorize the following Crisis Standard of Care Treatment Orders.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date/Time:</td>
</tr>
</tbody>
</table>

---

**ACTIONS**

**General Prehospital EMS Directions**

Implement Changes to accommodate BLS Transport:
- No continuous cardiac monitoring or pacing
- No continuous drug therapy (during transport)

### Initial to Execute

<table>
<thead>
<tr>
<th>Initial to Execute</th>
<th>Treatment Protocol</th>
<th>Altered Treatment</th>
<th>Altered Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-1 Pulseless Arrest</td>
<td>No Treatment</td>
<td>Refer to Public Access #</td>
<td></td>
</tr>
<tr>
<td>C-5 Return of Spontaneous Circulation</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>C-6 Tachycardia With Pulses</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>C-7 Bradycardia</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>C-8 Chest Pain or Suspected Symptoms of Cardiac Origin</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>R-1 Airway Obstruction</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>R-2 Respiratory Arrest</td>
<td>Attempt to open airway and establish appropriate airway if appropriate</td>
<td>Refer to Public Access # for deceased. Schedule BLS Transport all others</td>
<td></td>
</tr>
<tr>
<td>R-3 Acute Respiratory Distress</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>M-1 Allergic Reaction/Anaphylaxis</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>M-2 Shock/Non-Traumatic Hypovolemia</td>
<td>Oral rehydration (water, electrolyte replacement fluids, etc.)</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>M-3 Phenothiazine/Dystonic Reaction</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>M-5 Ingestions and Overdoses</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
<td></td>
</tr>
<tr>
<td>Initial to Execute</td>
<td>Treatment Protocol</td>
<td>Altered Treatment</td>
<td>Altered Disposition</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>M-6</td>
<td>General Medical Treatment Protocol</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>M-7</td>
<td>Nausea/Vomiting (From Any Cause)</td>
<td>Treat for shock if indicated. Trial of p.o. fluids. Trial of OTC antiemetic, if available (follow label instructions)</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>N-1</td>
<td>Altered Level of Consciousness</td>
<td>No Change</td>
<td>Competent adults with normal V/S, blood glucose and mental status 10 minutes after ALS intervention may be released-at-scene if a cause of their condition and its solution has been identified</td>
</tr>
<tr>
<td>N-2</td>
<td>Seizure</td>
<td>No Change</td>
<td>Competent adults with normal V/S, blood glucose and mental status 10 minutes after ALS intervention may be released-at-scene if a cause of their condition and its solution has been identified</td>
</tr>
<tr>
<td>N-3</td>
<td>Suspected CVA/Stroke</td>
<td>Aspirin</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>OB/G-1</td>
<td>Childbirth</td>
<td>Oxygen and IV fluid. Deliver baby</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>E-1</td>
<td>Heat Stress</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>E-2</td>
<td>Cold Stress Emergencies: Hypothermia</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>E-3</td>
<td>Frostbite</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>E-7</td>
<td>Hazardous Materials Exposure Treatment Protocol</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>E-8</td>
<td>Nerve Agent Treatment</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>T-1</td>
<td>General Trauma Management</td>
<td>If shock develops and does not respond to initial IV bolus of 2000 mL, provide palliative care only. Provide immobilization, ice packs and pain control (EMS or OTC pain meds as appropriate). Clean wounds with soap and water. Remove foreign bodies and debris. Irrigate with NS or clean water as available and apply dressings. Signs of infection require higher level of care.</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>Initial to Execute</td>
<td>Treatment Protocol</td>
<td>Altered Treatment</td>
<td>Altered Disposition</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>T-2</td>
<td>Tension Pneumothorax</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>T-6</td>
<td>Isolated Extremity Injury – Including Hip or Shoulder Injuries</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>T-8</td>
<td>Hemorrhage</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>T-10</td>
<td>Burns: Thermal &amp; Electrical</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-1</td>
<td>General Pediatric Protocol</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-2</td>
<td>Neonatal Resuscitation</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-3</td>
<td>Apparent Life Threatening Event</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-4</td>
<td>Pulseless Arrest</td>
<td>No Treatment</td>
<td>Refer to Public Access #</td>
</tr>
<tr>
<td>P-6</td>
<td>Bradycardia – With Pulses</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-8</td>
<td>Tachycardia – With Pulses</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-10</td>
<td>Foreign Body Airway Obstruction</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-12</td>
<td>Respiratory Failure/Arrest</td>
<td>Attempt to open airway and establish appropriate airway if appropriate</td>
<td>Refer to Public Access # for deceased. Schedule BLS Transport all others</td>
</tr>
<tr>
<td>P-14</td>
<td>Respiratory Distress – Wheezing</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-16</td>
<td>Respiratory Distress – Stridor</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-18</td>
<td>Allergic Reaction/Anaphylaxis</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-20</td>
<td>Shock</td>
<td>Oral rehydration (water, electrolyte replacement fluids, etc.)</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-22</td>
<td>Overdose and/or Poisoning (Including Nerve Agent Treatment)</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-24</td>
<td>Altered Level of Consciousness</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-26</td>
<td>Seizure</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-28</td>
<td>Burns: Thermal &amp; Electrical</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-30</td>
<td>Isolated Extremity Injury – Including Hip or Shoulder Injuries</td>
<td>No Change</td>
<td>Schedule BLS Transport</td>
</tr>
<tr>
<td>P-32</td>
<td>Nausea/Vomiting (From Any Cause)</td>
<td>Treat for shock if indicated. Trial of p.o. fluids. Trial of OTC antiemetic, if available (follow label instructions)</td>
<td>Schedule BLS Transport</td>
</tr>
</tbody>
</table>

Additions/Notes:
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### Medical & Health Disaster Responsibilities by Primary Agency (838-D)

This matrix outlines the specific responsibilities of agencies with Medical and Health responsibilities within the county, during the planning, and response phase of all disaster incidents. This matrix does not identify the agency that would assume the lead role (Incident Command Role) during a disaster incident. Refer to the County Emergency Operations Plan to identify lead agencies for specific types of incidents.

#### Preparedness

<table>
<thead>
<tr>
<th>Preparedness</th>
<th>Placer</th>
<th>Yuba</th>
<th>Sutter</th>
<th>Nevada</th>
<th>Colusa</th>
<th>Butte</th>
<th>Shasta</th>
<th>Tehama</th>
<th>Siskiyou</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Ensure the development of a medical and health disaster plan for the operational area</td>
<td>PHD*</td>
<td>PHD*</td>
<td>PHD*</td>
<td>PHD*</td>
<td>PHD*</td>
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<td>* SSV responsible for Multiple Casualty Incident Plan</td>
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<tr>
<td>(2) Ensure 24-hour point of contact (MHOAC) in operational area for RDMHC/S</td>
<td>SHARED PHD/SSV</td>
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<td>SHARED PHD/SSV</td>
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<td>Contact MHOAC thru PHD or PSAP</td>
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#### Response

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<td>(1) Assessment of immediate medical needs</td>
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<td>* Prehospital EMS Providers ** Other healthcare providers</td>
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<tr>
<td>(2) Coordination of disaster medical and health resources</td>
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<td>* Prehospital EMS Providers ** Other Med/Health Resources Reimbursement/payment authorizations thru PHD/OES (or EOC if activated)</td>
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<tr>
<td>• Approve all Medical/Health mutual-aid requests</td>
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<td>* Prehospital EMS Providers ** Other Med/Health Resources Reimbursement/payment authorizations thru PHD/OES (or EOC if activated)</td>
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<tr>
<td>• Assist in the coordination of medical and health disaster resources in operational area</td>
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<td>*Unless DOC/EOC is activated. SSV to act as liaison with local EMS providers</td>
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<tr>
<td>• Authorize release of medical/health caches to be used by field (e.g. CHEMPACK, Pharmacy Cache, ACS cache, etc.)</td>
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<td>CHEMPACK assets released directly from hospital for in-county. Out of County requests through RDMHC/MHOAC process</td>
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<td>CHEMPACK assets released directly from hospital for in-county. Out of County requests through RDMHC/MHOAC process</td>
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<tr>
<td>• Coordinate reception of medical mutual aid</td>
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#### Response (continued)

<table>
<thead>
<tr>
<th>(3) Coordination of patient distribution and medical evaluations</th>
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<td>* Prehospital patients ** All other patient types</td>
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| (4) Coordination with inpatient and emergency care providers | SSV* | SSV* | SSV* | SSV* | SSV* | SSV* | SSV* | SSV* | SSV* | *Delivery of prehospital pt's ** All other coordination |
|---|---|---|---|---|---|---|---|---|---|
| PHD** | PHD** | PHD** | PHD** | PHD** | PHD** | PHD** | PHD** | PHD** | PHD** | |

| (5) Coordination of out of hospital medical care providers (facilities) | PHD | PHD | PHD | PHD | PHD | PHD | PHD | PHD | PHD | |

| (6) Coordination and integration with fire agencies’ personnel, resources, and emergency fireprehospital medical services | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | Local Jurisdiction | |

- **Plan automatic aid**
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction

- **Authorize EMS System Austere Care/Alternate Treatment Standards**
  - SSV*
  - SSV*
  - SSV*
  - SSV*
  - SSV*
  - SSV*
  - SSV*
  - SSV*
  - SSV*

  *Unless DOC/EOC is activated

- **Authorize modified medical dispatch public pre-arrival instructions**
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*
  - Local Protocol*

  * Unless DOC/EOC is activated

- **Authorize MCI alerts and systems (other than routine MCIs)**
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
  - Local Jurisdiction
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  - Local Jurisdiction

- **Authorize deviation from unit dispatch standards**
  - Local Jurisdiction
  - Local Jurisdiction
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  - Local Jurisdiction
  - Local Jurisdiction

- **Authorize non-standard transport for patients (buses, private vehicles etc)**
  - SSV
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<tr>
<th>(7) Coordination of providers of non-fire based prehospital emergency medical services</th>
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- **Plan automatic aid**
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- **Authorize EMS System Austere Care/Alternate Treatment Standards**
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- **Authorize modified medical dispatch public pre-arrival instructions**
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<tr>
<td>• Authorize MCI alerts and systems (other than routine MCIs)</td>
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<td>• Authorize deviation from unit dispatch standards</td>
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<tr>
<td>• Authorize non-standard transport for patients (busses, private vehicles etc)</td>
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<tr>
<td>(8) Coordination of the establishment of temporary Field Treatment Sites (FTS)</td>
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<td>(9) Coordination of the establishment of Alternate Care Sites (ACS)</td>
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<tr>
<td>(10) Health Surveillance and epidemiological analysis of community health status</td>
<td>PHD</td>
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<td>(11) Assurance of food safety</td>
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<td>(12) Management of exposure to hazardous agents</td>
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<td>(13) Provision or coordination of mental health services</td>
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<td>(14) Provision of medical and health public information protective action recommendations</td>
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<td>(15) Provision or coordination of vector control services</td>
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<td>(16) Assurance of drinking water safety</td>
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<td>(17) Assurance of the safe management of liquid, solid, and hazardous wastes</td>
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<tr>
<td>(18) Investigation and control of communicable diseases</td>
<td>PHD</td>
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* SSV to coordinate Paramedic protocols & procedures only. Logistics/facility activation & support from OES/PHD.
SUBJECT: PHYSICIAN ON SCENE

PURPOSE:

To define patient care responsibilities when a physician is on the scene of a medical emergency, and one or more Paramedic or Advanced EMT personnel are present.

AUTHORITY:

California Health and Safety Code, Division 2.5, Section 1797.220, 1798.2.

California Code of Regulations, Title 22, Division 9.

POLICY:

It is the policy of the S-SV EMS Region that a Paramedic or Advanced EMT encountering a physician on the scene shall maintain responsibility for patient care unless the physician assumes responsibility for patient care and accompanies the patient to the hospital.

A Paramedic or Advanced EMT may assist the patient's physician provided the Paramedic or Advanced EMT operates within the approved S-SV scope of practice.

PROCEDURE:

A. Physician is a bystander:

1. Take care of patient first.

2. Require I.D. If needed, use card (see below) provided by State of California.

3. If the physician wishes to do more than offer assistance, s/he must get approval from the base/modified base hospital.

4. If the physician wishes care given that does not conform to the Paramedic or Advanced EMT personnel’s training, scope of practice, and S-SV EMS protocols, explain to the physician that the Paramedic license or Advanced EMT certification prevents the Paramedic or Advanced EMT from doing anything that does not conform to their training, scope of practice, S-SV EMS policies/protocols, and base hospital medical control.
SUBJECT: PHYSICIAN ON SCENE

a. The physician must:

- Assume responsibility for the patient.
- Provide the care s/he wishes.
- Accompany the patient to the hospital.

5. In the event of conflict, follow orders of medical control and document events.

B. Physician is patient's physician:

1. Require I.D. if physician is unknown to Paramedic or Advanced EMT.

2. The patient's physician may administer medication from his/her drug inventory.

3. The Paramedic or Advanced EMT may follow the patient's physician's orders if they do not conflict with the Paramedic or Advanced EMT scope of practice.

4. If there is a conflict between patient's physician's orders and the Paramedic or Advanced EMT scope of practice, explain that you can legally only treat within the S-SV Paramedic or Advanced EMT scope of practice. Contact medical control and ask patient's physician to discuss any problem issues with the base hospital.

CROSS REFERENCES:

Policy and Procedure Manual
Base Hospital/ Modified Base Hospital Contact, Reference No. 812.
Advanced EMT Scope of Practice, Reference No. 802
Paramedic Scope of Practice, Reference No. 803.

EMSA/CMA PHYSICIAN ON SCENE SAMPLE CARD:
SUBJECT: AUTOMATIC TRANSPORT VENTILATOR USE DURING INTERFACILITY TRANSPORTS

PURPOSE:

To provide a mechanism for Paramedics to be permitted to use, monitor, and adjust Automatic Transport Ventilators (ATV’s) during interfacility transports (IFT’s).

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.220

California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

Only those Paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director on ATV’s will be permitted to use them during interfacility transports.

Only those ALS ambulance providers approved by the S-SV EMS Agency Medical Director will be permitted to use ATV’s during interfacility transports.

PROCEDURE:

A. Paramedics will not initiate ventilator support.

B. Signed transfer orders from the transferring physician shall be obtained prior to transport. Transport orders must provide for maintaining and adjusting ventilations via ATV settings during transport.

C. Ventilator support must be regulated by an ATV familiar to the Paramedic.

D. If an ATV failure occurs and cannot be corrected, the Paramedic shall discontinue use of the ATV, initiate ventilation by bag-valve, and notify the transferring physician and base/modified base hospital as soon as possible. The S-SV EMS Agency Medical Director shall be notified of the ATV failure within 24 hours.

E. Paramedics shall continually observe the patient and document patient response to any changes while the device is operational.
F. ATV initial settings and any subsequent changes shall be documented on the ePCR.

G. The Paramedic is responsible for all airway management and must frequently reassess tracheostomy/endotracheal tube placement—which shall be checked after each patient movement (bilateral breath sounds, end-tidal CO₂).

H. A non-invasive BP monitor device shall be utilized. Vital signs will be monitored and documented every 15 minutes and immediately if there is any change in patient status or adjustment of the ATV setting. Vital signs shall also include pulse oximetry and cardiac monitoring which shall be maintained throughout transport.

I. A continuous end-tidal CO₂ detector device must be employed during transport (capnograph or waveform capnography are preferred).

J. The ventilator that the Paramedic provider will be using must be able to match the existing ventilator settings and shall include the following minimum device features (including circuit):

1. Modes:
   a. Assist Control (AC)
   b. Synchronized Intermittent Mandatory Ventilation (SIMV)
   c. Controlled Mechanical Ventilation (CMV)

2. Set rate of ventilations

3. Adjustable delivered tidal volume

4. Adjustable FiO₂

5. Positive End-Expiratory Pressure (PEEP)

6. Adjustable Inspiratory and Expiratory ratios (I:E ratio)

7. Peak airway pressure gauge

8. Alarms:
   a. Peak airway pressure
   b. Disconnect

K. Agencies approved for use of this equipment must follow the manufacturer instructions regarding the use, maintenance, cleaning and regular testing of this device. At a minimum, ATV equipment shall undergo preventative testing and maintenance by qualified manufacturer’s representative personnel or designee annually.
L. Paramedics must be thoroughly trained and regularly retrained on the device’s use. Such training shall occur no less than annually and shall be documented.

CROSS REFERENCES:

Prehospital Care Policy Manual

Paramedic Interfacility Transport Optional Skills: Transferring Hospital Requirements, Reference No. 341

Paramedic Interfacility Transport Optional Skills: Service Provider Requirements and Responsibilities, Reference No. 441

Paramedic Interfacility Transport Optional Skills: Application and Approval Process, Reference No. 442
PURPOSE:

To identify those patients who are at greatest risk for severe injury and determine the most appropriate facility to transport persons with different injury types and severities.

AUTHORITY:

California Health & Safety Code, Division 2.5; Chapter 6, Article 2.5, Section 1798.160 et seq.

California Code of Regulations, Title 22, Division 9, Chapter 7

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6101a1.htm?s_cid=rr6101a1_w

PRINCIPLES:

The trauma triage criteria indicate high-risk factors for serious traumatic injuries. Trauma patients meeting triage criteria should be transported as soon as possible, and time on scene should be limited. Procedures at the scene should be limited to triage, patient assessment, airway management, control of external hemorrhage and appropriate immobilization. Additional interventions should be completed en route with the exception of those incidents requiring prolonged extrication.

TRAUMA CENTER LEVELS

Level I: A Level I Trauma Center has the greatest amount of resources and personnel for care of the injured patient. Typically, it is also a tertiary medical care facility that provides leadership in patient care, education and research for trauma, including prevention programs.

Level II: A Level II Trauma Center offers similar resources as a Level I facility, differing only by the lack of research activities for a Level I designation.
Level I and II Pediatric: Level I and II Pediatric Trauma Centers focus specifically on pediatric trauma patients. Level I Pediatric Trauma Centers require some additional pediatric specialties and are research and teaching facilities.

Level III: A Level III Trauma Center is capable of assessment, resuscitation and emergency surgery, if warranted. Injured patients are stabilized before transfer, if indicated, to a facility with a higher level of care according to pre-existing arrangements.

Level IV: A Level IV Trauma center is capable of providing 24-hour physician coverage, resuscitation and stabilization to injured patients before they are transferred, if indicated.

PATIENT DESTINATION:

A. Patients with an unmanageable airway shall be transported to the closest receiving hospital for airway stabilization.

B. For any patient who is found to meet at least one of the Anatomic or Physiologic Trauma Triage Criteria:

1. If the time closest designated Trauma Center is a Level I or Level II Trauma Center, transport directly to the Level I or Level II Trauma Center.

2. If the time closest designated trauma center is a Level III Trauma Center, contact the Level III Trauma Center for a destination decision.

C. If a trauma patient meets Mechanism of Injury Trauma Criteria only, with or without meeting any of the Special Considerations Criteria, prehospital personnel shall contact the closest base/modified base hospital for a destination decision.

D. If a trauma patient meets the Special Considerations Criteria only, without meeting any of the Anatomic, Physiologic or Mechanism of Injury trauma triage criteria, contact with the closest base/modified base hospital shall be made for a destination decision when prehospital personnel determine that transport to a trauma center may be in the best interest of the patient.

E. The use of EMS aircraft for transport of trauma patients should provide a clinically significant reduction in arrival time to the most appropriate designated trauma center. If the total time for air transport exceeds the ground ambulance arrival time, air transport may not be indicated.

F. Pediatric Trauma Patient Destination

1. When ground ambulance or EMS aircraft (if utilized) transport times do not exceed 45 minutes, all children ≤ 14 years of age who meet Anatomic and/or
Physiologic Trauma Triage Criteria should be transported directly to a designated pediatric trauma center.

2. If a pediatric patient meets criteria for direct transport to a designated pediatric trauma center, but the patient’s condition is so critical that any additional transport time may jeopardize the patient’s life, the patient shall be transported to the closest designated trauma center.

G. Prehospital personnel shall notify the designated receiving trauma center of the patient’s pending arrival as soon as possible.

TRAUMA TRIAGE CRITERIA:

A. Physiologic Criteria:

1. Respiratory Rate < 10 or > 29 breaths per minute (<20 in infant aged <1 year) or need for ventilatory support, or
2. Glasgow Coma Score ≤ 13, or
3. Systolic Blood Pressure < 90

B. Anatomic Criteria:

1. All penetrating injuries to the head, neck, chest, torso, and extremities proximal to the elbow or knee
2. Chest wall instability or deformity (e.g. flail chest)
3. Two or more proximal long-bone fractures
4. Paralysis
5. Pelvic fractures
6. Amputation proximal to wrist or ankle
7. Crushed, degloved or mangled or pulseless extremity
8. Open or depressed skull fracture

C. Mechanism of Injury Criteria:

1. High-risk auto crash (one or more of the following):
   a. Ejections (partial or complete) from automobile
   b. Death in the same passenger compartment
SUBJECT: TRAUMA TRIAGE CRITERIA

c. Intrusion, including roof: > 12 inches at occupant site or > 18 inches at any site

2. Non-Automotive crash > 20 mph including, but not limited to: motorcycle, ATV, go-cart, bicycle, skateboard, watercraft and aircraft

3. Auto vs Pedestrian / Bicycle: thrown, run over, or with significant (> 20 mph) impact

4. Adults who fall > 20 feet

5. Children who fall > 10 feet or two to three times the height of the child

6. Other high energy impact

D. Special Considerations

1. Age:
   a. Adults > 55 years of age
      • SBP <110 might represent shock after 65 years of age
      • Low impact mechanism (e.g. ground level falls) might result in severe injury.
   b. Children ≤ 14 years of age
      • Children should be triaged to pediatric capable trauma centers when possible

2. Anticoagulation or bleeding disorders
   • Patients with head injury are at high risk for rapid deterioration

3. Burns:
   a. With trauma mechanism: Triage to trauma center
   b. Without trauma mechanism: Triage to burn facility

4. Pregnancy > 20 weeks

5. EMS provider judgment in conjunction with medical control

TRAUMA REGISTRY:

All hospitals receiving trauma patients from the S-SV EMS Region shall supply data to the S-SV EMS Trauma Registry.
## GLASGOW COMA SCALE (GCS): Adult & Pediatric Combined GCS

Note: Modifications for age appropriate response for infant/young child are typed in bold print.

<table>
<thead>
<tr>
<th>EYE OPENING RESPONSE</th>
<th>BEST VERBAL RESPONSE</th>
<th>BEST MOTOR RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 pts = Open spontaneously</td>
<td>5 pts = Oriented &amp; converses</td>
<td>6 pts = Obey commands</td>
</tr>
<tr>
<td></td>
<td>Cries appropriately, coos, babbles</td>
<td>Normal spontaneous movement</td>
</tr>
<tr>
<td>3 pts = To verbal stimuli</td>
<td>4 pts = Disoriented &amp; converses</td>
<td>5 pts = Localizes pain</td>
</tr>
<tr>
<td>To speech, to shout</td>
<td>Irritable cry</td>
<td>Withdraws to touch</td>
</tr>
<tr>
<td>2 pts = To painful stimuli</td>
<td>3 pts = Inappropriate words</td>
<td>4 pts = Flexion withdrawal</td>
</tr>
<tr>
<td></td>
<td>Inappropriate crying/screaming</td>
<td>Withdraws to pain</td>
</tr>
<tr>
<td>1 pt = No response</td>
<td>2 pts = Incomprehensible sounds/words</td>
<td>3 pts = Flexion abnormal (decorticate)</td>
</tr>
<tr>
<td></td>
<td>Grunts</td>
<td></td>
</tr>
<tr>
<td>1 pt = No response</td>
<td>2 pts = Extension (decerebrate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 pt = No response</td>
<td></td>
</tr>
</tbody>
</table>

Risk of injury is high with GCS < 14  
COMA is defined by GCS ≤ 8  
Any patient with a GCS ≤ 8, consider intubation and hyperventilate at 20 to 24 breaths per minute to reduce cerebral swelling.

## CROSS REFERENCES:

Policy and Procedure Manual
- Patient Destination, Reference No. 505
- Hospital Capabilities, Reference No. 505-A
- Multiple Casualty Incidents, Reference No. 837
- Crisis Standard of Care Procedures, Reference No. 838
SIERRA-SACRAMENTO VALLEY EMS AGENCY

CERTIFICATION/RECERTIFICATION
REFERENCE NO. IX

SUBJECT: INDEX

REFERENCE NO. 900

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901-A EMT Skills Competency Verification Form
902   Advanced EMT Certification and Recertification
902-A Advanced EMT Skills Competency Verification Form
903   EMT/AEMT Denial of Certification/Accreditation, Incident Investigation, Determination of Action, Notification and Administrative Hearing Process
904   Emergency Medical Responder (EMR) Certification/Recertification
904-A Emergency Medical Responder (EMR) Skills Competency Verification Form
913   Paramedic Accreditation to Practice
913-A S-SV EMS Agency Paramedic Employee Status Report
915   Mobile Intensive Care Nurse Authorization/Reauthorization
927   EMS Incident Reporting & Investigation
927-A Prehospital Provider Incident Tracking Form
928   Paramedic Accreditation/Licensure Review Process
977   EMT Optional Skill: Requirements for Accreditation
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SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

PURPOSE:

To establish a mechanism for an individual to be certified as a California State Emergency Medical Technician (EMT) by the S-SV EMS Agency.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.80, 1797.170, 1797.175, 1797.177, 1797.210 and 1798.200.

California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100079, 100080 and 100081. Chapter 10, Article 4, Section 100347

California Penal Code, Sections 11075 and 11105.2

POLICY:

Any individual certified as an EMT shall be recognized as an EMT on a statewide basis. No individual shall hold himself or herself out to be an EMT unless that individual is currently certified as such by the S-SV EMS Agency or another California EMT certifying entity.

PROCEDURE

EMT Initial Certification Requirements

A. An individual who meets one of the following criteria shall be eligible for initial certification upon fulfilling the requirements specified in item (B) of this section of the policy:

1. Pass the National Registry EMT-Basic Written* and Skills** Examination and have one of the following:

   a. A valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to California Code of Regulations, Title 22, Division 9, Chapter 2 within the last two (2) years.
b. Documentation of successful completion of an approved out-of-state initial EMT training course, within the last two (2) years, that meets the requirements of California Code of Regulations, Title 22, Division 9, Chapter 2.

c. A current and valid out-of-state EMT certificate.

*NREMT Written Examination results will be valid for application purposes two (2) years from the date of examination.

**NREMT Skills Examination results will be valid for one (1) year for the purpose of being eligible for the National Registry of Emergency Medical Technicians EMT-Basic Written Examination.

2. Possess a current and valid National Registry EMT-Basic registration certificate.

3. Possess a current and valid out-of-state or National Registry EMT-Intermediate or Paramedic Certificate.

4. Possess a current and valid California Advanced EMT or EMT-II certification or a current and valid California Paramedic License.

B. In addition to meeting one of the criteria specified in item (A) of this section of the policy, to be eligible for initial certification, an individual shall:

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

2. Complete a criminal history background check no longer than 60 days prior to the date the certification application is submitted.

3. Complete an application form that contains this statement: “I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California.”

4. Disclose any certification or licensure action:

   a. Against an EMT, Advanced EMT, or EMT-II certificate, or any denial of certification by a LEMSA, including any active investigations;

   b. Against a paramedic license, or any denial of licensure by the Authority, including any active investigations;
c. Against any EMS-related certification or license of another state or other issuing entity, including any active investigations; or

d. Against any health-related license.

5. Provide copies of the following:

a. A course completion record or other appropriate documentation indicated in item (A) of this section of the policy.

b. A valid U.S. state-issued Drivers License or identification card.

c. A current CPR certification which is taught to the curriculum standards of the American Heart Association, American Red Cross or the National Safety Council at the Health Care Provider or equivalent level.

6. Pay the established fee. All fees are non-refundable and non-transferable.

C. The S-SV EMS Agency shall issue a wallet-sized EMT certificate card within ten (10) business days to eligible individuals who apply for an EMT certificate and successfully complete the requirements of this policy.

D. The effective date of initial certification shall be the day the certificate is issued.

E. The expiration date for an initial EMT certificate shall be as follows:

1. For an individual who meets the criteria listed in item (A)(1)(a) or (A)(1)(b) of this section of the policy, the expiration date shall be the last day of the month two (2) years from the effective date of the initial certification.

2. For an individual who meets the criteria listed in item (A)(1)(c), (A)(2), (A)(3) or (A)(4) of this section of the policy, the expiration date shall be the lesser of the following:

   a. The last day of the month two (2) years from the effective date of the initial certification; or

   b. The expiration date of the certificate or license used to establish eligibility under item (A) of this section of the policy.

F. The EMT shall be responsible for notifying the S-SV EMS Agency of her/his proper and current mailing address and shall notify the S-SV EMS Agency in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and EMT registry number.

G. An EMT shall only be certified by one (1) certifying entity during a certification period.
EMT Recertification

A. In order to recertify, an EMT shall:

1. Possess a current EMT Certification issued in California.

2. Obtain at least twenty-four (24) hours of continuing education hours (CEH) from an approved CE provider in accordance with the provisions contained in California Code of Regulations, Title 22, Division 9, Chapter 11, or successfully complete a twenty-four (24) hour refresher course from an approved EMT training program. An individual who is currently licensed in California as a paramedic or certified as an Advanced EMT or EMT-II, or who has been certified within six (6) months of the date of application, may be given credit for CEH earned as a paramedic, Advanced EMT or EMT-II to satisfy the CE requirement for EMT recertification as specified in this policy.

3. Complete an application form and other processes as specified in items (B)(3)-(B)(7) of the ‘EMT Initial Certification Requirements’ section of this policy.

4. Submit a completed skills competency verification form, Reference No. 901-A. Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.

B. The S-SV EMS Agency shall issue a wallet-sized EMT certificate card within ten (10) business days to eligible individuals who apply for EMT recertification and successfully complete the requirements of this policy.

C. If the EMT recertification requirements are met within six (6) months prior to the current certification expiration date, the S-SV EMS Agency shall make the effective date of recertification the date immediately following the expiration date of the current certificate. The certification will expire two (2) years from the day prior to the effective date.

D. If the EMT recertification requirements are met greater than six (6) months prior to the expiration date, the S-SV EMS Agency shall make the effective date of recertification the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date will be the last day of the month two (2) years from the effective date.

E. A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the EMT recertification requirements. In order to qualify for this exception, the individual shall submit proof of their membership in the Armed Forces of the United States and documentation of their deployment starting and ending dates. Continuing education credit may be given for documented training that meets the
requirements contained in California Code of Regulations, Title 22, Division 9, Chapter 11 while the individual was deployed on active duty. The documentation shall include verification from the individual’s Commanding Officer attesting to the training attended.

Recertification of an Expired California EMT Certificate

A. The following requirements apply to individuals who wish to be eligible for recertification after their California EMT Certificates have expired:

1. For a lapse of less than six (6) months, the individual shall complete the requirements specified in items (A)(2)-(A)(4) of the ‘EMT Recertification’ section of this policy.

2. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall:
   a. Complete the requirements specified in items (A)(2)-(A)(4) of the ‘EMT Recertification’ section of this policy, and
   b. Complete an additional twelve (12) hours of continuing education.

3. For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall:
   a. Complete the requirements specified in items (A)(2)-(A)(4) of the ‘EMT Recertification’ section of this policy, and
   b. Complete an additional twenty-four (24) hours of continuing education, and
   c. Pass the written and skills certification exams as specified in item (A)(1) of the ‘EMT Initial Certification’ section of this policy.

4. For a lapse of greater than twenty-four (24) months the individual shall meet all of the requirements specified in items (A) and (B) of the ‘EMT Initial Certification’ section of this policy.

B. For individuals who meet the requirements of items (A)(1), (A)(2), or (A)(3) of this section of the policy, the S-SV EMS Agency shall make the effective date of recertification the day the certificate is issued. The certification expiration date will be the last day of the month two (2) years from the effective date.

C. For individuals who meet the requirements of item (A)(4) of this section of the policy, the S-SV EMS Agency shall make the certification effective and expiration dates consistent with items (D) and (E) of the ‘EMT Initial Certification’ section of this policy.
D. The S-SV EMS Agency shall issue a wallet-sized EMT certificate card within ten (10) business days to eligible individuals who apply for EMT recertification and successfully complete the requirements of this policy.

Application Processing

1. A completed and signed application and all required supporting documentation must be submitted to the S-SV EMS Agency prior to processing. Incomplete applications will not be processed.

2. Incomplete applications will be maintained by the S-SV EMS Agency for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.

3. The S-SV EMS Agency will process completed applications within 10 business days.

CROSS REFERENCES:

Policy and Procedure Manual

EMT/AEMT Incident Investigations, Determination of Action, Notification and Administrative Hearing Process, Reference No. 903
SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) CERTIFICATION & RECERTIFICATION

PURPOSE:

To provide a mechanism for individuals to obtain S-SV EMS Agency certification as an Emergency Medical Responder (EMR).

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.210 & 1797.212.

California Code of Regulations, Title 22, Division 9, Chapter 1.5.

POLICY:

A. S-SV EMS Agency certification is required for all prehospital personnel functioning as an EMR in the S-SV EMS region.

B. This policy does not apply to personnel who are certified by another EMR certifying entity (CAL FIRE, CHP, etc.).

C. No individual shall hold himself or herself out to be an EMR unless that individual is currently certified as such by the S-SV EMS Agency or another EMR certifying entity.

PROCEDURE:

EMR Initial Certification Requirements

A. An individual who meets one of the following criteria shall be eligible for initial certification upon fulfilling the requirements specified in item (B) of this section of the policy:

1. Posses a valid course completion record, dated within the past twelve (12) months, from an S-SV EMS Agency Approved EMR training program, or

2. Possess a valid course completion record or other documented proof of successful completion, dated within the past twelve (12) months, of any initial training program that meets or exceeds the U.S. Department of Transportation
Emergency Medical Responder National Emergency Medical Services Educational Standards and Instructional Guidelines, or

3. Possess a current and valid First Responder or EMR certification card issued by another certifying entity. Acceptance of a First Responder or EMR certification card issued by another certifying entity shall be at the sole discretion of the S-SV EMS Agency.

B. In addition to meeting one of the criteria specified in item (A) of this section of the policy, to be eligible for initial certification, an individual shall:

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

2. Complete a criminal history background check no longer than 60 days prior to the date the certification application is submitted.

3. Complete an application form that contains this statement: “I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to S-SV EMS Agency EMR certification. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMR in the S-SV EMS region.”

4. Disclose any certification or licensure action:

   a. Against an EMR, EMT, Advanced EMT, or EMT-II certificate, or any denial of certification by a California Local EMS Agency, including any active investigations;

   b. Against a paramedic license, or any denial of licensure by the California EMS Authority, including any active investigations;

   c. Against any EMS-related certification or license of another state or other issuing entity, including any active investigations; or

   d. Against any health-related license.

5. Provide copies of the following:

   a. A course completion record or current certification card from another certifying entity indicated in item (A) of this section of the policy.

   b. A copy of a valid U.S. state-issued Drivers License or identification card.
SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) CERTIFICATION & RECERTIFICATION

   c. A copy of a current CPR certification which is taught to the curriculum standards of the American Heart Association, American Red Cross or the National Safety Council at the Health Care Provider or equivalent level.

6. Pay the certification fee. All fees are non-refundable and non-transferable.

C. The S-SV EMS Agency shall issue a wallet-sized EMR certificate card within ten (10) business days to eligible individuals who apply for an EMR certificate and successfully complete the requirements of this policy.

D. The effective date of initial certification shall be the day the certificate is issued.

E. The expiration date for an initial EMR certificate shall be as follows:

1. For an individual who meets the criteria listed in item (A)(1) or (A)(2) of this section of the policy, the expiration date shall be the last day of the month two (2) years from the effective date of the initial certification.

2. For an individual who meets the criteria listed in item (A)(3) of this section of the policy, the expiration date shall be the lesser of the following:

   a. The last day of the month two (2) years from the effective date of the initial certification; or

   b. The expiration date of the certificate used to establish eligibility under item (A) of this section of the policy.

F. The EMR shall be responsible for notifying the S-SV EMS Agency of her/his proper and current mailing address and shall notify the S-SV EMS Agency in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and EMR certification number.

EMR Recertification

A. In order to recertify, an EMR shall:

1. Possess a current EMR Certification issued by the S-SV EMS Agency.

2. Obtain at least twelve (12) hours of continuing education hours (CEH) from an approved CE provider in accordance with the provisions contained in California Code of Regulations, Title 22, Division 9, Chapter 11, or successfully complete a twelve (12) hour refresher course from an S-SV EMS Agency approved EMR training program.
SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) CERTIFICATION & RECERTIFICATION

3. Complete an application form and other processes as specified in items (B)(3)-(B)(6) of the ‘EMR Initial Certification Requirements’ section of this policy.

4. Submit a completed skills competency verification form, Reference No. 904-A. Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.

B. The S-SV EMS Agency shall issue a wallet-sized EMR certificate card within ten (10) business days to eligible individuals who apply for EMR recertification and successfully complete the requirements of this policy.

C. If the EMR recertification requirements are met within six (6) months prior to the current certification expiration date, the S-SV EMS Agency shall make the effective date of recertification the date immediately following the expiration date of the current certificate. The certification will expire two (2) years from the day prior to the effective date.

D. If the EMR recertification requirements are met greater than six (6) months prior to the expiration date, the S-SV EMS Agency shall make the effective date of recertification the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date will be the last day of the month two (2) years from the effective date.

E. A S-SV EMS Agency certified EMR who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the EMR recertification requirements. In order to qualify for this exception, the individual shall submit proof of their membership in the Armed Forces of the United States and documentation of their deployment starting and ending dates. Continuing education credit may be given for documented training that meets the requirements contained in California Code of Regulations, Title 22, Division 9, Chapter 11 while the individual was deployed on active duty. The documentation shall include verification from the individual’s Commanding Officer attesting to the training attended.

Recertification of an Expired S-SV EMS Agency EMR Certificate

A. The following requirements apply to individuals who wish to be eligible for recertification after their S-SV EMS Agency EMR Certificate has expired:

1. For a lapse of less than six (6) months, the individual shall complete the requirements specified in items (A)(2)-(A)(4) of the ‘EMR Recertification’ section of this policy.
SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) CERTIFICATION & RECERTIFICATION

2. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall:
   a. Complete the requirements specified in items (A)(2)-(A)(4) of the ‘EMR Recertification’ section of this policy, and
   b. Complete an additional twelve (12) hours of continuing education.

3. For a lapse of greater than twelve (12) months the individual shall meet all of the requirements specified in items (A) and (B) of the ‘EMR Initial Certification’ section of this policy.

B. For individuals who meet the requirements of this section of the policy, the S-SV EMS Agency shall make the effective date of recertification the day the certificate is issued. The certification expiration date will be the last day of the month two (2) years from the effective date.

C. The S-SV EMS Agency shall issue a wallet-sized EMR certificate card within ten (10) business days to eligible individuals who apply for EMR recertification and successfully complete the requirements of this policy.

Denial, Suspension, or Revocation of an S-SV EMS Agency EMR Certificate

S-SV EMS Agency EMR certification may be denied, suspended, or revoked for any act that is substantially related to the qualifications, functions, and duties of an EMR and is evidence of a threat to the public health and safety, per Division 2.5 of the California Health and Safety Code Section 1798.200.

Application Processing

1. A completed and signed application and all required supporting documentation must be submitted to the S-SV EMS Agency prior to processing. Incomplete applications will not be processed.

2. Incomplete applications will be maintained by the S-SV EMS Agency for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.

3. The S-SV EMS Agency will process completed applications within 10 business days.
SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

PURPOSE:

To establish the requirements for obtaining and maintaining accreditation to practice as a paramedic in the S-SV EMS region.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.84, 1797.185, 1797.194, 1797.214

California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100166

POLICY:

A. In order to be eligible for initial paramedic accreditation, an individual shall:

1. Provide a completed S-SV EMS Agency Paramedic Accreditation Application.

2. Provide a copy of a current California State Paramedic License.

3. Provide a copy of a current U.S. state-issued Drivers License or identification card.

4. Pay the accreditation fee.

5. Attend and successfully complete an S-SV EMS Agency paramedic orientation/accreditation class.


7. Successfully complete a supervised pre-accreditation field evaluation consisting of a minimum of 5 (five), but no more than 10 ALS contacts with an S-SV EMS Agency approved ALS service provider in the S-SV EMS region.
SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

a. This requirement may be met by the submission of actual ALS patient care reports or a letter verifying successful completion of this requirement from a management/QI representative of an S-SV EMS Agency approved ALS service provider.

b. This requirement may be waived in one of the following circumstances:

• By providing documentation of five (5) ALS contacts in the S-SV EMS region during the paramedic education program field internship within the previous six (6) months.

• If the paramedic accreditation candidate has been actively employed as a field paramedic in the State of California within the past six (6) months and has a minimum of one (1) year's experience as a paramedic.

8. Pass an examination on S-SV EMS Agency policies and protocols with a minimum score of 80%. If the examination is failed twice, the orientation/accreditation class shall be repeated prior to re-testing.

9. If all of the above requirements are not met within 60 days of completion of the S-SV EMS Agency orientation/accreditation class, the candidate must repeat all initial paramedic accreditation requirements to be eligible for accreditation.

10. Upon completion of all the above requirements, the individual will be issued an S-SV EMS Agency Paramedic Accreditation Card with the same expiration date as the individual’s current California State Paramedic License.

B. Paramedic accreditation applicant temporary authorization to practice:

1. The paramedic accreditation applicant may practice in the basic scope of practice, with an S-SV EMS Agency approved ALS service provider, as a second paramedic until s/he is accredited.

2. The paramedic accreditation applicant may only perform the S-SV EMS Agency paramedic local optional scope of practice while in the presence of the field evaluator who is ultimately responsible for patient care.

3. This temporary authorization to practice shall be valid for a maximum of sixty (60) days, after which time all S-SV EMS Agency paramedic accreditation requirements must be met in order to continue to practice as a paramedic in the S-SV EMS region.

C. Critical Care Paramedic (CCP) additional accreditation requirements:

In order for an individual to be eligible for accreditation, in the S-SV EMS
SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

Agency’s CCP scope of practice, the individual must obtain and maintain CCP certification from the Board of Critical Care Transport Certification (BCCTPC).

D. Requirements for maintaining/renewing paramedic accreditation:

To maintain continuous accreditation, a paramedic shall:

1. Provide a completed S-SV EMS Agency Paramedic Accreditation Application.

2. Provide a copy of a current California State Paramedic License.

3. Maintain and provide proof of continuous PALS or PEPP recognition.

   PALS/PEPP recognition will not be required at the time of initial accreditation in the S-SV EMS region, but will be required at the time of paramedic accreditation renewal.

4. Complete S-SV EMS Agency mandated education. This education includes, but is not limited to, policies, procedures, protocols, skills, medications and/or devices/equipment.

5. The ALS service provider will provide orientation to all paramedic personnel for all new and/or revised policies, procedures, and/or protocols.

   a. The ALS service provider shall be responsible for ensuring that all field employees are kept current on local policies and procedures.

   b. The ALS service provider shall be responsible for ensuring that S-SV EMS Agency mandatory education requirements are completed by their paramedic personnel, including annual infrequently used skills verification of maintenance.

6. Upon completion of all the above requirements, the individual will be issued an S-SV EMS Agency Paramedic Accreditation Card with the same expiration date as the individual’s current California State Paramedic License.

E. Lapse in maintaining paramedic accreditation:

A lapse of S-SV EMS Agency paramedic accreditation shall require the following in order to be eligible for renewal:

1. A lapse of less than two years:

   a. Meet all of the requirements listed in the “Requirements for maintaining/renewing paramedic accreditation” section of this policy.
b. Provide the S-SV EMS Agency with written documentation of completion of orientation/training, by an S-SV EMS Agency approved ALS service provider, to all S-SV EMS Agency policy/protocol updates during the lapse of accreditation.

2. A lapse of more than two years:
   a. All requirements for initial accreditation shall be met.

F. S-SV EMS Agency paramedic accreditation denial, probation, suspension, or revocation:

The S-SV EMS Agency Medical Director may deny, place on probation, suspend, or revoke accreditation if the paramedic does not maintain current licensure, does not meet local accreditation requirements, or for cause. Due process and appeals procedures specified in S-SV EMS Agency ‘Paramedic Accreditation/Licensure Review Process’ policy (Reference No. 928) will be followed for any accreditation denial, probation, suspension, and/or revocation.

G. ALS service provider agency responsibilities:

If there is a change in the employment status of an S-SV EMS Agency accredited paramedic employee; the ALS service provider shall submit a completed “S-SV Paramedic Employee Status Report” (Reference No. 913-A) to the S-SV EMS Agency within 30 calendar days.

APPLICATION PROCESSING:

A. A completed and signed application and all required supporting documentation must be submitted to the S-SV EMS Agency prior to processing. Incomplete applications will not be processed.

B. Incomplete applications will be maintained by the S-SV EMS Agency for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.

C. The S-SV EMS Agency will process completed applications within 10 business days.

CROSS REFERENCES:

Policy and Procedure Manual

Paramedic Scope of Practice, Reference No. 803

EMS Incident Reporting & Investigation, Reference No. 927
SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

Paramedic Accreditation/Licensure Review Process, Reference No. 928

Infrequently Used Skills: Verification of Maintenance/Regional Training Module, Reference No. 1110
# Paramedic Employee Status Report (Policy Addendum 913-A)

Send Completed Forms to the S-SV EMS Agency  
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – certification@ssvems.com

## Reporting Entity Information:

<table>
<thead>
<tr>
<th>Name of ALS service provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/title of person completing this form:</td>
</tr>
<tr>
<td>Effective date (hire date, resignation date, status change date, etc.):</td>
</tr>
</tbody>
</table>

## Paramedic Information:

<table>
<thead>
<tr>
<th>Paramedic Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State License #:</td>
</tr>
</tbody>
</table>

### Paramedic Status

- [ ] Has been hired as a paramedic, has a current S-SV EMS Agency Paramedic Accreditation, and will be working in the S-SV EMS Region
- [ ] Has been hired as a paramedic and will be working in the S-SV EMS Region upon successful completion of the S-SV EMS Agency Accreditation process
- [ ] Is no longer employed by our agency as a paramedic
- [ ] Other:

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**Note:** The ALS service provider is responsible for verifying S-SV EMS Agency accreditation status for all of their paramedic personnel prior to allowing them to work as a paramedic in the S-SV EMS region and on an ongoing basis.
SUBJECT: EMS INCIDENT REPORTING & INVESTIGATION

PURPOSE:

To define the reporting and investigation requirements of EMS system participants.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.200, 1798, Chapter 7, Section 1798.200, et seq., 1799.112

California Code of Regulations, Title 22, Division 9, Chapters 2, 3, 4, 6 & 12

Base/Modified Base Hospital and Prehospital Service Provider Agreements

Prehospital Service Provider Agreements/EOA Contracts

LEGAL BASIS:

A. EMT/Advanced EMT (AEMT) Personnel:

An employer of an EMT or AEMT may conduct investigations, as necessary, and take disciplinary action against an EMT or AEMT who is employed by that employer for conduct alleging or indicating the possibility of a threat to the public health and safety as listed in Division 2.5 of the Health and Safety Code, Section 1798.200. The employer shall notify the medical director of the local EMS agency that has jurisdiction in the county in which the alleged violation occurred within three days when an allegation has been validated as a potential violation of one or more of the items listed under Division 2.5 of the Health and Safety Code, Section 1798.200.

Each employer of an EMT or AEMT employee shall notify the medical director of the local EMS agency that has jurisdiction in the county in which a violation of one or more of the items listed under Division 2.5 of the Health and Safety Code, Section 1798.200 within three days after the EMT or AEMT is terminated or suspended for a disciplinary cause, the EMT or AEMT resigns following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or the EMT or AEMT is removed from EMT/AEMT-related duties for a disciplinary cause after the completion of the employer's investigation.
SUBJECT: EMS INCIDENT REPORTING & INVESTIGATION

At the conclusion of an investigation, the employer of an EMT or AEMT may develop and implement, in accordance with the guidelines for disciplinary orders, temporary suspensions, and conditions of probation adopted pursuant to Division 2.5 of the Health and Safety Code, Section 1797.184, a disciplinary plan for the EMT or AEMT. Upon adoption of the disciplinary plan, the employer shall submit that plan to the local EMS agency within three working days. The employer's disciplinary plan may include a recommendation that the medical director of the local EMS agency consider taking action against the holder's certificate.

B. Paramedic Personnel:

When information comes to the attention of the medical director of the local EMS agency that a paramedic license holder has committed any act or omission that appears to constitute grounds for disciplinary action under Division 2.5 of the Health and Safety Code, Section 1798.200, the medical director of the local EMS agency may evaluate the information to determine if there is reason to believe that disciplinary action may be necessary.

If the medical director refers the matter to the EMS Authority for further investigation and/or discipline of the paramedic license holder, the recommendation shall include all documentary evidence collected by the medical director in evaluating whether or not to make that referral. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by Section 6254 of the Government Code. In deciding what level of disciplinary action is appropriate in the case, the authority shall consult with the medical director of the local EMS agency.

REPORTABLE INCIDENTS

A reportable incident is an occurrence or allegation of any of the following:

A. Sentinel Events – A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

B. Breach of the standard of care (i.e. failure to assess, patient abandonment, failure to act).

C. Any medication errors – errors in drug choice, dosage and route.

D. Treatment errors – Procedural errors (e.g. unrecognized esophageal intubation) or errors in assessment/application of treatment guidelines that lead to treatment errors (e.g. medication given or procedure done when not warranted).

E. Key equipment failure on a call directly related to the care of the patient.
SUBJECT: EMS INCIDENT REPORTING & INVESTIGATION

F. Care beyond the appropriate scope of practice.

G. Failure to follow S-SV EMS Agency policy or protocol.

H. Suspected violations of Division 2.5 Health & Safety Code 1798.200

I. Any alleged or known injury to a patient as a result of actions by EMS personnel.

POLICY:

A. Prehospital Personnel Responsibilities:

1. Immediately report the above defined incidents to an on-duty provider agency supervisor.

2. Immediately notify the RN or physician staff at the receiving facility if an error impacts or has a potential to impact patient health and well being.

3. Immediately notify the base hospital MICN and/or physician who directed the call regarding errors involving base/modified base hospital contact issues.

4. Within 24 hours of the incident, submit a written incident report to the provider agency supervisory personnel describing the details of the alleged incident.

5. Reasonably cooperate with the investigation of the alleged incident.

B. Prehospital Provider Agency Responsibilities:

1. If the prehospital provider agency is the reporting entity, the following procedures shall be followed:

   a. Provide a written report of the incident and any other incident related materials (ePCR, voice recordings, etc.) to the appropriate allied agency or hospital within 3 working days of becoming aware of a reportable incident.

   b. Provide reasonable and appropriate information to the investigating agency to assist them in completing their investigation.

2. If the prehospital provider agency receives notification of a reportable incident from another entity, the following procedures shall be followed:

   a. Acknowledge receipt of the incident to the reporting party within 24 hours.

   b. Conduct a thorough incident investigation which shall include, but not be limited to, the following:
• Review of all incident related documentation including the ePCR(s), incident reports and any other documentation provided by the reporting party or related to the investigation.

• Review of other materials related to the incident (medical reports, voice recordings, etc.) if appropriate.

• Interviews and/or discussions with appropriate prehospital, hospital, allied agency personnel or members of the general public.

• Determine what action, if any, should be taken as a result of the findings of the investigative process. Such actions may include one or more of the following:
  o No action – After a complete investigation, no action is necessary to resolve the issue
  o Remedial education
  o Provider disciplinary action
  o Referral to the S-SV EMS Agency and/or the California EMS Authority for potential certification/licensure action
  o Referral to the S-SV EMS Agency for possible case review and/or policy/protocol revision

• Investigations should be completed as soon as possible and should normally be resolved within 10 working days of notification. The reporting entity shall be advised if the investigation is expected to last longer than 10 working days and appropriate updates shall be provided.

• Prehospital providers shall utilize the S-SV EMS Prehospital Provider Incident Tracking Form (Reference No. 927-A) or similar form(s) to document the tracking and resolution(s) of all reportable incidents. This form is for internal provider tracking and shall be made available to the S-SV EMS Agency upon request or for any incident that requires referral to the S-SV EMS Agency for additional review and/or action.

  c. Provide a notification of resolution to the reporting agency/person(s). This notification shall be in compliance with current employment and confidentiality laws and at a minimum will advise that the incident has been investigated, resolved and closed.

C. Base/Modified Base/Receiving Hospital Responsibilities:

  1. If the base/modified base/receiving hospital is the reporting entity, the following procedures shall be followed:
SUBJECT: EMS INCIDENT REPORTING & INVESTIGATION

a. Provide a written report of the incident and any other incident related materials (patient outcome information, voice recordings, etc.) to the appropriate prehospital provider agency within 3 working days of becoming aware of a reportable incident.

b. Provide reasonable and appropriate information to the investigating agency to assist them in completing their investigation.

2. If the base/modified base/receiving hospital receives a concern/complaint from a prehospital provider that involves the EMS system, the following procedures shall be followed:

a. Conduct a thorough incident investigation.

b. Determine what action, if any, should be taken as a result of the findings of the investigative process. Such actions may include one or more of the following:

- No action – After a complete investigation, no action is necessary to resolve the issue
- Remedial education
- Provider disciplinary action
- Referral to the S-SV EMS Agency for possible case review and/or policy/protocol revision

c. Provide a notification of resolution to the reporting agency/person(s). This notification shall be in compliance with current employment and confidentiality laws and at a minimum will advise that the incident has been investigated, resolved and closed.

D. Prehospital provider agencies and base/modified base/receiving hospitals shall report in writing (927-A or other appropriate forms of documentation), within 10 working days of the incident, to the S-SV EMS agency the following:

1. Any action of certified/licensed prehospital care personnel which results in an apparent deficiency of medical care or constitutes a violation under Section 1798.200 of the Health & Safety Code as listed below:

a. Fraud in the procurement of any certificate or license under this division.

b. Gross negligence.

c. Repeated negligent acts.

d. Incompetence.
The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.

Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.

Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

Unprofessional conduct exhibited by any of the following:

- The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT, AEMT, or Paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT, AEMT, or Paramedic, from using that force that is reasonably necessary to effect a lawful arrest or detention.

- The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law.

- The commission of any sexually related offense specified under Section 290 of the Penal Code.
2. Sentinel Events.

3. Any alleged or known injury to a patient as a result of actions or omissions by EMS personnel.

4. Any incident believed to require S-SV EMS Agency notification/involvement or if the reporting entity is not satisfied with the provider’s investigation and/or resolution of the incident.

E. EMT/AEMT employers shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days after an allegation has been validated as potential for disciplinary cause.

EMT/AEMT employers shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days of the occurrence of any of following:

1. The EMT/AEMT is terminated or suspended for a disciplinary cause.

2. The EMT/AEMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or

3. The EMT/AEMT is removed from EMT/AEMT – related duties for a disciplinary cause after the completion of the employer’s investigation.

F. Paramedic employers shall report in writing to the local EMS agency medical director and the State EMS authority and provide all supporting documentation within 30 days of whenever any of the following actions are taken (H&S, Division 2.5 Section 1799.112):

1. A paramedic is terminated or suspended for disciplinary cause or reason.

2. A paramedic resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.

3. A paramedic is removed from paramedic duties for disciplinary cause or reason following the completion of an internal investigation.

   a. The reporting requirements above do not require or authorize the release of information or records of a paramedic who is also a peace officer protected by Section 832.7 of the Penal Code.

   b. For purposes of this section, "disciplinary cause or reason" means only an action that is substantially related to the qualifications, functions, and duties of a paramedic and is considered evidence of a threat to the public health and safety as identified in subdivision (c) of Section 1798.200.
G. The report to the S-SV EMS Agency shall be sent by an authorized representative of the base/modified base/receiving hospital or the prehospital care provider agency and must contain, at a minimum, the following information:

1. The name(s) of all personnel involved in the incident(s).

2. The date(s) time(s) and location(s) of the incident(s).

3. The alleged facts of the incident(s).

4. Copies of all available written/audio material regarding the incident(s).

H. The S-SV EMS Agency will provide a notification of resolution to the reporting agency/person(s) for all incidents referred to the Agency. This notification shall be in compliance with current employment and confidentiality laws and will be completed in a timely manner based on the details of the specific incident.

CROSS REFERENCES:

   Prehospital Care Policy Manual

   Continuous Quality Improvement Program (CQIP), Reference No. 620

   EMT/AEMT Denial of Certification/Accreditation, Incident Investigation, Determination of Action, Notification and Administrative Hearing Process, Reference No. 903
**S-SV EMS Prehospital Provider Incident Tracking Form**

**CONFIDENTIAL**

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

**Reporting Entity Information:**

<table>
<thead>
<tr>
<th>Name of Reporting Party:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Email Address:</td>
</tr>
<tr>
<td>Date Received:</td>
</tr>
<tr>
<td>Receipt Acknowledgement Date:</td>
</tr>
</tbody>
</table>

**Incident Logistics:**

<table>
<thead>
<tr>
<th>County: Colusa</th>
<th>Butte</th>
<th>Nevada</th>
<th>Placer</th>
<th>Shasta</th>
<th>Siskiyou</th>
<th>Sutter</th>
<th>Tehama</th>
<th>Yuba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Investigation Opened:</td>
<td></td>
<td></td>
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<td>Incident Date:</td>
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<td>Incident Time:</td>
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<td>EMS #:</td>
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<td>Incident Location:</td>
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<tr>
<td>Prehospital Agency(ies) Involved:</td>
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<tr>
<td>Hospital(s) Involved:</td>
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<tr>
<td>Personnel Involved:</td>
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<td></td>
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</tr>
</tbody>
</table>

**Type of Reportable Incident(s):**

<table>
<thead>
<tr>
<th>Sentinel Event</th>
<th>Breach of the Standard of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Error</td>
<td>Treatment Error</td>
</tr>
<tr>
<td>Key Equipment Failure Related to Patient Care</td>
<td>Care Beyond the Appropriate Scope of Practice</td>
</tr>
<tr>
<td>Failure to Follow S-SV EMS Agency Policy or Protocol</td>
<td>Suspected Violation of Div. 2.5 H&amp;S Code 1798.200</td>
</tr>
<tr>
<td>Alleged or Known Injury to a Patient as a Result of Actions by EMS Personnel</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Specific Issue(s):**

<table>
<thead>
<tr>
<th>Airway</th>
<th>Inappropriate Behavior</th>
<th>MICN Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA/RAS</td>
<td>Interpersonal</td>
<td>Patient Assessment</td>
</tr>
<tr>
<td>Base/Modified Base Contact</td>
<td>Manpower/Resource Utilization</td>
<td>Patient Transfer</td>
</tr>
<tr>
<td>Destination</td>
<td>MCI</td>
<td>Patient Turnover</td>
</tr>
<tr>
<td>Dispatch</td>
<td>Medical Control</td>
<td>Physician Issues</td>
</tr>
<tr>
<td>Documentation</td>
<td>Medication Broken/Missing</td>
<td>Policy Clarification</td>
</tr>
<tr>
<td>Equipment Failure</td>
<td>Medication Error</td>
<td>Scope of Practice</td>
</tr>
<tr>
<td>Equipment Utilization</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>
S-SV EMS Prehospital Provider Incident Tracking Form

CONFIDENTIAL

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

Description of Incident (attach additional documentation if necessary):

Incident Investigation Checklist (items used/reviewed during the incident investigation):

<table>
<thead>
<tr>
<th>Base/Mod. Base Audio Files</th>
<th>Dispatch Audio Files</th>
<th>PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base/Mod. Base Documentation</td>
<td>Dispatch Logs</td>
<td>RAS/AMA Forms</td>
</tr>
<tr>
<td>Cardiac Monitor/AED Reports</td>
<td>Incident Reports</td>
<td>S-SV EMS Policy/Protocol</td>
</tr>
</tbody>
</table>

☐ Prehospital Personnel Interview(s):

☐ Interviews/Discussions With Other Personnel:

☐ Other:
Comments (attach additional documentation if necessary):

Resolution(s):

☐ No Action Required ☐ Remedial Education ☐ Disciplinary Action

☐ Referral to the S-SV EMS Agency and/or the California EMS Authority for Potential Certification/Licensure Action

☐ Referral to the S-SV EMS Agency for Possible Case Review and/or Policy/Protocol Revision

☐ Other:

S-SV EMS Agency Referral Date:

Date Notification of Resolution Provided to Reporting Party:

Investigator Information

Name/Title of Person Completing Investigation:
<table>
<thead>
<tr>
<th>Reference No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>Continuing Education (CE) Provider Requirements and Approval Process</td>
</tr>
<tr>
<td>1001-A</td>
<td>EMT/Advanced EMT Continuing Education Requirement Overview</td>
</tr>
<tr>
<td>1001-B</td>
<td>EMS Continuing Education (CE) Provider Application</td>
</tr>
<tr>
<td>1002</td>
<td>EMT Training Program Requirements and Approval Process</td>
</tr>
<tr>
<td>1003</td>
<td>Advanced EMT Training Program Requirements &amp; Approval Process</td>
</tr>
<tr>
<td>1004</td>
<td>Emergency Medical Responder Training Program Requirements &amp; Approval Process</td>
</tr>
<tr>
<td>1005</td>
<td>Paramedic Training Program Requirements &amp; Approval Process</td>
</tr>
</tbody>
</table>
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CONTINUING EDUCATION (CE) PROVIDER PROGRAM APPLICATION

<table>
<thead>
<tr>
<th>☐ Initial</th>
<th>☐ Renewal</th>
</tr>
</thead>
</table>

**Type of Entity or Organization**

- ☐ EMS Training Program
- ☐ University/College/School
- ☐ Service Provider
- ☐ Other Governmental Agency
- ☐ Base Hospital
- ☐ Other Hospital
- ☐ Individual
- ☐ Other CE Provider

**CE Provider Name:**

- Street Address:
- City: State: Zip Code: Telepho: Fax: Email:

**CE Provider Program Director Name:**

**CE Provider Clinical Director Name:**

I certify that I have read and understand the S-SV EMS Agency “Continuing Education (CE) Provider Requirements and Approval Process” policy (Reference No. 1001) and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit & review provisions described. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.

__________________________________________________________  __________________________________
CE Provider Program Director Signature                  Date

__________________________________________________________  __________________________________
CE Provider Program Clinical Director Signature          Date

**Required Supporting Documentation**

- ☐ Resume and copy of a current EMS certification or license for the CE Program Director
- ☐ Resume, copy of a current EMS certification or license, and copies of required instructor course completion documentation (Fire Instructor 1A & 1B, EMS Educator Course, etc.) for the CE Clinical Director
- ☐ Copy of proposed CE certificate

Submit Completed applications and the following supporting documents to:

Linda Combs, Data Analyst (Linda.Combs@ssvems.com), S-SV EMS Agency Rocklin Office

**S-SV EMS Agency Use Only**

<table>
<thead>
<tr>
<th>Application Received</th>
<th>Reviewed By</th>
<th>Approval Date</th>
<th>Renewal Date</th>
<th>Provider #</th>
<th>Method of Payment</th>
</tr>
</thead>
</table>

Rocklin Office
5995 Pacific Street
Rocklin, CA 95677
916-625-1702
916-825-1730 (fax)

Redding Office
2775 Bechelli Lane
Redding, CA 96002
530-722-6617
530-222-3007 (fax)

www.ssvems.com
SUBJECT: EMT TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

PURPOSE:

To provide a mechanism for the review of EMT Training Program applicants for compliance to state law, regulations, and S-SV EMS Agency policies.

AUTHORITY:

California Health and Safety Code, Division 2.5

California Code of Regulations, Title 22, Division 9, Chapter 2

EMT TRAINING PROGRAM APPROVAL TYPES:

A. EMT Training Program:

The purpose of an EMT Training Program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during inter-facility transfer within an organized EMS system.

B. National Registry of Emergency Medical Technicians (NREMT) EMT Transition Course:

1. The NREMT EMT transition course is a requirement for recertification with NREMT as part of NREMT's commitment to fully implement their transition to the new National EMS Scope of Practice Model, National Education Standards, and relevant Instructional Guidelines.

2. Completion of a transition course is not necessary to maintain California EMT Certification.

3. The following are the timeframes allowed by NREMT for completing the transition:

<table>
<thead>
<tr>
<th>NREMT-Basic expires</th>
<th>Complete Paramedic Transition by</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31, 2011</td>
<td>March 31, 2015</td>
</tr>
<tr>
<td>March 31, 2012</td>
<td>March 31, 2016</td>
</tr>
</tbody>
</table>
4. An approved EMT training program may provide NREMT EMT transition courses upon approval by the S-SV EMS Agency as specified in this policy.

**POLICY:**

The Sierra-Sacramento Valley Emergency Medical Services Agency (S-SV EMS Agency) has the primary responsibility for approving and monitoring the performance of EMT Training Programs located within the S-SV EMS region, to ensure their compliance with state law, regulations, guidelines and S-SV EMS Agency policies.

A. Eligibility for EMT Program Approval:

1. EMT training may be offered only by approved training programs. Eligibility for program approval shall be limited to:

   a. Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.

   b. Medical training units of a branch of the Armed Forces including the Coast Guard of the United States.

   c. Licensed general acute care hospitals which meet the following criteria:

      - Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of California Code of Regulations, Title 22, Division 5; and

      - Provide continuing education to other health care professionals.

   d. Agencies of government including public safety agencies.

   e. Local EMS Agencies (LEMSAs).

B. Procedure for EMT Training Program Approval:

1. Eligible training programs may submit a written request for EMT program approval to the S-SV EMS Agency.

2. The S-SV EMS Agency shall review and approve the following prior to approving an EMT training program:

b. A statement verifying CPR training equivalent to the current American Heart Association’s Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course.

c. Samples of written and skills examinations used for periodic testing.

d. A final skills competency examination.

e. A final written examination.

f. The name and qualifications of the program director, program clinical coordinator, and principal instructor(s).

g. Provisions for clinical experience, as specified in this policy.

h. Provisions for course completion by challenge, including a challenge examination (if different from final examination).

i. Provisions for a twenty-four (24) hour refresher course including items (a)-(f) above, required for recertification.


j. The location at which the courses are to be offered and their proposed dates.

k. Table of contents listing the required information required in this section of the policy, with corresponding page numbers.

C. Didactic and Skills Laboratory:

An approved EMT training program shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during skills practice/laboratory sessions.
D. Clinical Experience for EMT:

Each approved EMT training program shall have written agreement(s) with one or more general acute care hospital(s) and/or operational ambulance provider(s) or rescue vehicle provider(s) for the clinical portion of the EMT training course. The written agreement(s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s). Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience.

E. EMT Training Program Notification:

1. The S-SV EMS Agency shall notify the training program submitting its request for training program approval within seven (7) working days of receiving the request that:

   a. The request has been received,

   b. The request contains or does not contain the information required in this policy,

   c. What information, if any, is missing from the request.

2. Program approval or disapproval shall be made in writing by the S-SV EMS Agency to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed three (3) months.

3. The S-SV EMS Agency shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

4. Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program approval specified in this policy.

5. Approved EMT training programs shall also receive approval as a continuing education CE provider effective the same date as the EMT training program approval. The CE program expiration date shall be the same expiration date as the EMT training program. The CE provider shall comply with all of the requirements contained in California Code of Regulations, Title 22, Division 9, Chapter 11.
6. The S-SV EMS Agency shall notify the California EMS Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, frequency and cost for both basic and refresher courses, student eligibility, and program approval/expiration date of program approval.

F. Teaching Staff:

Each EMT training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this section precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions of this section:

1. Each EMT training program shall have an approved program director who shall be qualified by education and experience in methods, materials, and evaluation of instruction which shall be documented by at least forty (40) hours in teaching methodology. The courses include but are not limited to the following examples:

   a. State Fire Marshal Instructor 1A and 1B,
   
   b. National Fire Academy’s Instructional Methodology,
   
   c. Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.

2. Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to:

   a. Administering the training program.
   
   b. Approving course content.
   
   c. Approving all written examinations and the final skills examination.
   
   d. Coordinating all clinical and field activities related to the course.
   
   e. Approving the principal instructor(s) and teaching assistants.
   
   f. Signing all course completion records.
g. Assuring that all aspects of the EMT training program are in compliance with this policy and other related laws/regulations.

3. Each training program shall have an approved program clinical coordinator who shall be either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:

a. Responsibility for the overall quality of medical content of the program;

b. Approval of the qualifications of the principal instructor(s) and teaching assistant(s).

4. Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. The courses include but are not limited to the following examples:

a. State Fire Marshal Instructor 1A and 1B,

b. National Fire Academy’s Instructional Methodology,

c. Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course. and who shall:

- Be a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California; or,

- Be an Advanced EMT or EMT who is currently certified in California.

- Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.

- Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.
5. Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.

G. EMT Training Program Review and Reporting:

1. All program materials specified in this policy shall be subject to periodic review by the S-SV EMS Agency.

2. All programs shall be subject to periodic on-site evaluation by the S-SV EMS Agency.

3. Any person or agency conducting a training program shall notify the S-SV EMS Agency in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in, program director, program clinical coordinator, principal instructor, change of address, phone number, or contact person.

4. For the purposes of this policy, student records shall be kept for a period of not less than four (4) years.

H. Withdrawal of EMT Training Program Approval:

Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this policy may result in denial, probation, suspension or revocation of program approval by the S-SV EMS Agency. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

1. The S-SV EMS Agency shall notify the approved EMT training program course director in writing, by registered mail, of the provisions of this policy with which the EMT training program is not in compliance.

2. Within fifteen (15) working days of receipt of the notification of noncompliance, the approved EMT training program shall submit in writing, by registered mail, to the S-SV EMS Agency one of the following:

   a. Evidence of compliance with the provisions of this policy, or

   b. A plan for meeting compliance with the provisions of this policy within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
3. Within fifteen (15) working days of receipt of the response from the approved EMT training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMT training program, the S-SV EMS Agency shall notify the California EMS Authority and the approved EMT training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the EMT training program approval.

4. If the S-SV EMS Agency decides to suspend, revoke, or place an EMT training program on probation the notification specified in this section of the policy shall include the beginning and ending dates of the probation or suspension and the 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) calendar days from the date of the S-SV EMS Agency’s letter of decision to the California EMS Authority and the EMT training program.

I. Components of an Approved Program:

1. An approved EMT training program shall consist of all of the following:
   a. The EMT course, including clinical experience;
   b. Periodic and a final written and skill competency examinations;
   c. A challenge examination; and
   d. A refresher course required for recertification.

2. The S-SV EMS Agency may approve a training program that offers only refresher course(s).

J. EMT Training Program Required Course Hours:

1. The EMT course shall consist of not less than one-hundred sixty (160) hours. These training hours shall be divided into:
   a. A minimum of one hundred thirty-six (136) hours of didactic instruction and skills laboratory; and
   b. A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated.
c. Existing EMT training programs approved prior to April 1, 2013 shall have until April 1, 2014 to meet the minimum hourly requirements specified in this section.

2. The minimum hours shall not include the examinations for EMT certification.

K. Required Course Content:

1. The content of an EMT course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), to result in the EMT being competent in the EMT basic scope of practice specified in California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100063. The U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009) can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address: http://ems.gov/pdf/811077a.pdf

2. Training in the use of hemostatic dressings shall consist of not less than one (1) hour to result in the EMT being competent in the use of the dressing. Included in the training shall be the following topics and skills:

   a. Review of basic methods of bleeding control to include but not be limited to direct pressure, pressure bandages, tourniquets, and hemostatic dressings;

   b. Review treatment of open chest wall injuries;

   c. Types of hemostatic dressings; and

   d. Importance of maintaining normal body temperature.

3. At the completion of initial training, a student shall complete a competency-based written and skills examination for controlling bleeding and the use of hemostatic dressings.

L. Required Testing:

Each component of an approved program shall include periodic and final competency-based examinations to test the knowledge and skills specified in this policy. Satisfactory performance in these written and skills examinations shall be demonstrated for successful completion of the course. Satisfactory performance shall be determined by pre-established standards, developed and/or approved by the S-SV EMS Agency.
M. EMT Training Program Course Completion Record:

1. An approved EMT training program provider shall issue a tamper resistant course completion record to each person who has successfully completed the EMT course, refresher course, or challenge examination.

2. The course completion record shall contain the following:
   a. The name of the individual.
   b. The date of course completion.
   c. Type of EMT course completed (i.e., EMT, refresher, or challenge), and the number of hours completed.
   d. The EMT approving authority (S-SV EMS Agency).
   e. The signature of the program director.
   f. The name and location of the training program issuing the record.
   g. The following statement in bold print: “This is not an EMT certificate”.

3. This course completion record is valid to apply for certification for a maximum of two (2) years from the course completion date and shall be recognized statewide.

4. The name and address of each person receiving a course completion record and the date of course completion shall be reported in writing to the S-SV EMS Agency within fifteen (15) working days of course completion.

5. Approved EMT training programs which are also approved EMT Certifying Entities need not issue a Course Completion record to those students who will receive certification from the same agency.

N. EMT Training Program Course Completion Challenge Process:

1. An individual may obtain an EMT course completion record from an approved EMT training program by successfully passing by pre-established standards, developed and/or approved by the S-SV EMS Agency, a course challenge examination if s/he meets one of the following eligibility requirements:
   a. The individual is currently licensed in the United States as a Physician, Registered Nurse, Physician Assistant, Vocational Nurse, or Licensed Practical Nurse.
b. The individual provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces of the United States within the preceding two (2) years that meets the U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009). Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete CE courses as a condition of certification.

2. The course challenge examination shall consist of a competency-based written and skills examination to test knowledge of the topics and skills prescribed in this policy.

3. An approved EMT training program shall offer an EMT challenge examination no less than once each time the EMT course is given (unless otherwise specified by the S-SV EMS Agency).

4. An eligible individual shall be permitted to take the EMT course challenge examination only one (1) time.

5. An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.

NREMT EMT TRANSITION COURSE REQUIREMENTS

A. NREMT EMT transition courses shall only be taught by S-SV EMS Agency approved EMT training programs.

B. Additional S-SV EMS Agency NREMT EMT transition course training program approval is required and shall consist of verification of all requirements listed in this section of the policy.

C. Course curriculum shall be consistent with the “gap content” identified in the ‘National Association of State EMS Officials’ “National EMS Education Standards Transition Template”. This gap content can be accessed at the following website address: http://www.nasemso.org/EMSEducationImplementationPlanning/documents/EMT-BasictoEMTJune2011.pdf

D. NREMT EMT transition course training programs shall ensure that their students complete the ICS-100, ICS-700, and HAZMAT First Responder Awareness level
training (or the equivalent to these courses) either as prerequisites or co-requisites to the transition course.

E. The NREMT EMT transition course shall consist of not less than 24 hours.

F. The NREMT EMT transition course completion records shall include the following information on a tamper resistant document:

1. NREMT-EMT’s name.
2. Transition course completion date.
3. The certificate must contain the following statement: "has completed a state approved EMT-Basic to Emergency Medical Technician (EMT) transition course".
4. Name of the sponsoring agency.
5. Signature of the individual responsible for the training.
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

PURPOSE:

To provide a mechanism for the review and approval of paramedic training programs in compliance with state law, regulations and S-SV EMS Agency policies.

AUTHORITY:

California Health and Safety Code, Division 2.5

California Code of Regulations, Title 22, Division 9, Chapter 4

PARAMEDIC TRAINING PROGRAMS APPROVAL TYPES:

A. Paramedic Training Program:

The purpose of a paramedic training program shall be to prepare individuals to render prehospital Advanced Life Support (ALS) within an organized EMS system.

B. Critical Care Paramedic (CCP) Training Program:

1. The purpose of a CCP training program shall be to prepare individuals to render critical care transport within an organized EMS system.

2. An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in this policy, may provide CCP training upon approval by the S-SV EMS Agency.

C. National Registry of Emergency Medical Technicians (NREMT) Paramedic Transition Course:

1. The NREMT paramedic transition course is a requirement for recertification with NREMT as part of NREMT's commitment to fully implement their transition to the new National EMS Scope of Practice Model, National Education Standards, and relevant Instructional Guidelines.

2. Completion of a transition course is not necessary to maintain California Paramedic Licensure.
3. The following are the timeframes allowed by NREMT for completing the transition:

<table>
<thead>
<tr>
<th>NREMT-Paramedic expires</th>
<th>Complete Paramedic Transition by</th>
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<tbody>
<tr>
<td>March 31, 2011</td>
<td>March 31, 2015</td>
</tr>
<tr>
<td>March 31, 2012</td>
<td>March 31, 2016</td>
</tr>
<tr>
<td>March 31, 2013</td>
<td>March 31, 2017</td>
</tr>
</tbody>
</table>

4. An approved paramedic training program may provide NREMT paramedic transition courses upon approval by the S-SV EMS Agency as specified in this policy.

POLICY:

The Sierra-Sacramento Valley Emergency Medical Services Agency (S-SV EMS Agency) has the primary responsibility for approving and monitoring the performance of paramedic training programs to ensure their compliance with state law, regulations, guidelines and local policy.

COMMISSION ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS (CAAHEP) ACCREDITATION REQUIREMENTS

A. All paramedic training programs previously approved by the S-SV EMS Agency shall be accredited and maintain current accreditation by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in order to continue to operate as an approved paramedic training program.

B. All new paramedic training programs approved by the S-SV EMS Agency shall submit their application, fee, and self study to CoAEMSP for accreditation within twelve (12) months of the start up of classes and receive and maintain CAAHEP accreditation no later than two (2) years from the date of application to CoAEMSP for accreditation in order to continue to operate as an approved paramedic training program.

C. Approved paramedic training programs shall provide the following information to all their paramedic training program applicants prior to the applicants’ enrollment in the paramedic training program:

1. The date by which the paramedic training program must submit their application and self study for initial accreditation or their application for accreditation renewal to CoAEMSP.

2. The date by which the paramedic training program must be initially accredited or have their accreditation renewed by CAAHEP.
3. Failure of the paramedic training program to submit their application and self study or their accreditation renewal to CoAEMSP by the date specified will result in closure of the paramedic training program by the S-SV EMS Agency, unless the S-SV EMS Agency has approved a plan for meeting compliance as provided in the ‘Denial or Withdrawal of Paramedic Training Program Approval’ subsection of this policy. When a paramedic training program approval is revoked under this provision, the paramedic training program course director must demonstrate to the satisfaction of the S-SV EMS Agency that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.

4. Failure of the paramedic training program to obtain or maintain CAAHEP accreditation by the required date will result in closure of the paramedic training program by the S-SV EMS Agency, unless the S-SV EMS Agency has approved a plan for meeting compliance as provided in the ‘Denial or Withdrawal of Paramedic Training Program Approval’ subsection of this policy. When a paramedic training program approval has been revoked under this provision, the paramedic training program course director must demonstrate to the satisfaction of the S-SV EMS Agency that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.

5. Students graduating from a paramedic training program that fails to apply for accreditation with, receive accreditation from, or maintain accreditation with, CAAHEP by the dates required will not be eligible for California State licensure as a paramedic.

D. Approved paramedic training programs shall submit to the S-SV EMS Agency all documents submitted to, and received from, CoAEMSP and CAAHEP for accreditation, including but not limited to, the initial application and self study for accreditation and the documents required for maintaining accreditation.

E. Approved paramedic training programs shall submit to the California EMS Authority the date their initial application was submitted to CoAEMSP and copies of documentation from CoAEMSP and/or CAAHEP verifying accreditation.

F. The S-SV EMS Agency shall revoke approval, in accordance with the ‘Denial or Withdrawal of Paramedic Training Program Approval’ subsection of this policy, of any paramedic training program which fails to comply with subsections A – D of this Section.
EMERGENCY MEDICAL SERVICES QUALITY IMPROVEMENT PROGRAM (EMSQIP)

Approved paramedic training programs shall participate in the S-SV EMS Agency EMSQIP. In addition, an approved paramedic training program, which is conducting a paramedic training program outside the jurisdiction of the S-SV EMS Agency, shall also agree to participate in the EMSQIP of the LEMSA which has jurisdiction where the paramedic training program is being conducted.

ELIGIBILITY FOR PROGRAM APPROVAL

Eligibility for Paramedic training program approval shall be limited to the following institutions:

A. Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau for Private Postsecondary Education.

B. Medical training units of a branch of the Armed Forces or Coast Guard of the United States.

C. Licensed general acute care hospitals which meet the following criteria:

1. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of California Code of Regulations, Title 22, Division 5; and

2. Provide continuing education (CE) to other health care professionals; and

3. Are accredited by a Centers for Medicare and Medicaid Services approved deeming authority

D. Agencies of government.

PARAMEDIC/CCP TRAINING PROGRAM REQUIREMENTS

A. Paramedic Training Program Teaching Staff:

1. Each training program shall have an approved program medical director who shall be a physician currently licensed in the State of California, who has two (2) years experience in prehospital care in the last five (5) years, and who is qualified by education or experience in methods of instruction. Duties of the medical director shall include, but not be limited to:
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

a. Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

b. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

c. Approval of provision for hospital clinical and field internship experiences.

d. Approval of principal instructor(s).

2. Each program shall have an approved course director who shall be licensed in California as a physician, a registered nurse who has a baccalaureate degree or a paramedic who has a baccalaureate degree, or shall be an individual who holds a baccalaureate degree in a related health field or in education.

The course director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one (1) year experience in an administrative or management level position and have a minimum three (3) years academic or clinical experience in prehospital care education within the last five (5) years. Duties of the course director shall include, but not be limited to:

a. Administration, organization and supervision of the educational program.

b. In coordination with the program medical director, approve the principal instructor, teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.

c. Ensure training program compliance with this policy and other related laws/regulations.

d. Sign all course completion records.

e. Ensure that the preceptor(s) are trained according to the curriculum specified in this policy.

3. Each training program shall have a principal instructor(s), who may also be the program medical director or course director if the qualifications for those positions are met, who shall:

a. Be a physician, registered nurse, physician assistant, or paramedic, licensed in the State of California.
b. Be knowledgeable in the course content of the United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards (DOT HS 811 077A, January 2009); and

c. Have six years (6) experience in an allied health field and an associate degree or two (2) years experience in an allied health field and a baccalaureate degree.

d. Be responsible for areas including, but not limited to, curriculum development, course coordination, and instruction.

e. Be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The courses include, but are not limited to the following examples:

- California State Fire Marshal (CSFM) “Training Instructor 1A, 1B, and 1C”
- National Fire Academy (NFA) “Fire Service Instructional Methodology” course
- A course that meets the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the National Association of EMS Educators’ EMS Educator Course

4. Each CCP training program shall have a principal instructor(s) who shall be licensed in California as a physician and knowledgeable in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or Flight Paramedic (FP) certification from the Board for Critical Care Transport Certification (BCCTPC). The CCP principal instructor(s) shall be qualified by education or experience in methods of instruction.

5. Each training program may have a teaching assistant(s) who shall be an individual(s) qualified by training and experience to assist with teaching of the course. A teaching assistant shall be supervised by a principal instructor, the course director and/or the program medical director.

6. Each paramedic training program shall have a field preceptor(s) who shall:

a. Be a licensed paramedic; and

b. Be working in the field as a licensed paramedic for the last two (2) years; and
c. Be under the supervision of a principal instructor, the course director and/or the program medical director; and

d. Have completed field preceptor training approved by the S-SV EMS Agency and/or comply with the field preceptor guidelines approved by the S-SV EMS Agency. Training shall include a curriculum that will result in the preceptor being competent to evaluate the paramedic student during the field internship phase of the training program, and how to do the following in cooperation with the paramedic training program:

- Conduct a daily field evaluation of students
- Conduct cumulative and final field evaluations of all students
- Rate students for evaluation using written field criteria
- Identify ALS contacts and requirements for graduation
- Identify the importance of documenting student performance
- Review field preceptor requirements contained in this policy
- Assess student behaviors using cognitive, psychomotor, and affective domains
- Create a positive and supportive learning environment
- Measure students against the standard of entry level paramedics
- Identify appropriate student progress
- Counsel the student who is not progressing
- Identify training program support services available to the student and the preceptor
- Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material

7. Each training program shall have a hospital clinical preceptor(s) who shall:

a. Be a physician, registered nurse or physician assistant currently licensed in the State of California.

b. Have worked in emergency medical care for the last two (2) years.

c. Be under the supervision of a principal instructor, the course director, and/or the program medical director.

d. Receive instruction in evaluating paramedic students in the clinical setting. Means of instruction may include, but need not be limited to, educational brochures, orientation, training programs, or training videos, and shall include how to do the following in cooperation with the paramedic training program:
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

- Evaluate a student’s ability to safely administer medications and perform assessments
- Document a student’s performance
- Review clinical preceptor requirements contained in this policy
- Assess student behaviors using cognitive, psychomotor, and affective domains
- Create a positive and supportive learning environment
- Identify appropriate student progress
- Counsel the student who is not progressing
- Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material

B. Didactic and Skills Laboratory:

An approved paramedic training program and/or CCP training program shall assure that no more than six (6) students are assigned to one instructor/teaching assistant during skills practice/laboratory.

C. Hospital Clinical Education and Training for Paramedic:

1. An approved paramedic training program shall provide for and monitor a supervised clinical experience at a hospital(s) that is licensed as a general acute care hospital and holds a permit to operate a basic or comprehensive emergency medical service. The clinical setting may be expanded to include areas commensurate with the skills experience needed. Such settings may include surgicenters, clinics, jails or any other areas deemed appropriate by the S-SV EMS Agency. The maximum number of hours in the expanded clinical setting shall not exceed forty (40) hours of the total clinical hours specified in the ‘Paramedic Training Program Required Course Hours’ subsection of this policy.

2. Hospital clinical training, for an approved CCP training program, shall consist of no less than ninety-four hours (94) in the following areas:

   a. Labor & Delivery (8 hours),
   b. Neonatal Intensive Care (16 hours),
   c. Pediatric Intensive Care (16 hours),
   d. Adult Cardiac Care (16 hours),
   e. Adult Intensive Care (24 hours),
   f. Adult Respiratory Care (6 hours), and
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

g. Emergency/Trauma Care (8 hours).

3. An approved paramedic training program and/or CCP training program shall not enroll any more students than the training program can commit to providing a clinical internship to begin no later than thirty (30) days after a student’s completion of the didactic and skills instruction portion of the training program. The paramedic training program course director and/or CCP training program course director and a student may mutually agree to a later date for the clinical internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student’s military duty, etc.).

4. Training programs, both paramedic and CCP, in nonhospital institutions shall enter into a written agreement(s) with a licensed general acute care hospital(s) that holds a permit to operate a basic or comprehensive emergency medical service for the purpose of providing this supervised clinical experience.

5. Paramedic clinical training hospital(s) and other expanded settings shall provide clinical experience, supervised by a clinical preceptor(s). The clinical preceptor may assign the student to another health professional for selected clinical experience. No more than two (2) students shall be assigned to one preceptor or health professional during the supervised clinical experience at any one time. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities, which may include the administration of any additional medications, approved by the S-SV EMS Agency Medical Director and the director of the California EMS Authority, to result in competency. Clinical assignments shall include, but are not to be limited to, emergency, cardiac, surgical, obstetric, and pediatric patients.

D. Field Internship Education and Training for Paramedic:

1. A field internship shall provide emergency medical care experience supervised at all times by an authorized field preceptor to result in the paramedic student being competent to provide the medical procedures, techniques, and medications specified in California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100146, in the prehospital emergency setting within an organized EMS system.

2. An approved paramedic training program shall enter into a written agreement with a paramedic service provider(s) to provide for field internship, as well as for a field preceptor(s) to directly supervise, instruct, and evaluate the students. The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency. If the paramedic service provider is located outside the jurisdiction of the S-SV EMS Agency, then the training program shall do the following:
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

a. In collaboration with the LEMSA in which the field internship will occur, ensure that the student has been oriented to that LEMSA, including local policies and procedures and treatment protocols.

b. Contact the LEMSA where the paramedic service provider is located and report to that LEMSA the name of the paramedic intern in their jurisdiction, the name of the EMS provider, and the name of the preceptor. The paramedic intern shall be under the medical control of the medical director of the LEMS in which the internship occurs.

3. The training program shall be responsible for ensuring that the field preceptor has the experience and training as specified in this policy.

4. The paramedic training program shall not enroll any more students than the training program can commit to providing a field internship to begin no later than ninety (90) days after a student’s completion of the hospital clinical education and training portion of the training program. The training program director and a student may mutually agree to a later date for the field internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student’s military duty, etc.).

5. For at least half of the ALS patient contacts specified in the ‘Paramedic Training Program Required Course Hours’ subsection of this policy, the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through release of the patient to a receiving hospital or medical care facility.

6. All interns shall be continuously monitored by the training program, in collaboration with the assigned field preceptor, regardless of the location of the internship, as described in written agreements between the training program and the internship provider. The training program shall document a student’s progress, based on the assigned field preceptor’s input, and identify specific weaknesses of the student, if any, and/or problems encountered by, or with, the student. Documentation of the student’s progress, including any identified weaknesses or problems, shall be provided to the student at least twice during the student’s field internship.

7. No more than one (1) EMT trainee, of any level, shall be assigned to a response vehicle at any one time during the paramedic student’s field internship.

E. Procedure for Paramedic Training Program Approval:

1. An S-SV EMS Paramedic Training Program Application may be obtained from the S-SV EMS Agency. Eligible agencies/institutions may submit the
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

completed application to the S-SV EMS Agency. Incomplete applications will not be processed.

2. The S-SV EMS Agency may deem a training program approved that has been accredited by the CAAHEP upon submission of proof of such accreditation, without requiring the paramedic training program to submit for review the information required in subsections 3 and 4 of this section.

3. The S-SV EMS Agency shall receive and review the following prior to program approval:

   a. For paramedic training programs, a statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards (DOT HS 811 077A January 2009).

   b. For CCP programs, a statement verifying that the CCP training program course content meets the requirements contained in California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100160(b). The CCP training program must also verify compliance with items c – f and h – i of this subsection.

   c. An outline of course objectives.

   d. Performance objectives for each skill.

   e. The name and qualifications of the training program course director, program medical director, and principal instructors.

   f. Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.

   g. Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.

   h. The location at which the courses are to be offered and their proposed dates.

   i. Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

   j. Written contracts or agreements between the paramedic training program and a provider agency(ies) for student placement for field internship training.
SUBJECT: PARAMEDIC TRAINING PROGRAM REQUIREMENTS AND APPROVAL PROCESS

4. The S-SV EMS Agency shall review the following prior to program approval:
   
a. Samples of written and skills examinations administered by the training program for periodic testing.

b. A final written examination administered by the training program.

c. Evidence that the training program provides adequate facilities, equipment, examination security, and student record keeping.

5. The S-SV EMS Agency shall submit to the California EMS Authority an outline of program objectives and eligibility on each training program being proposed for approval in order to allow the California EMS Authority to make the determination required by section 1797.173 of the Health and Safety Code. Upon request by the California EMS Authority, any or all materials submitted by the training program shall be submitted to the California EMS Authority.

F. Paramedic Training Program Approval:

1. The S-SV EMS Agency shall, within thirty (30) working days of receiving a request for training program approval, notify the requesting training program that the request has been received, and shall specify what information, if any, is missing.

2. Paramedic training program approval or disapproval shall be made in writing by the S-SV EMS Agency to the requesting training program after receipt of all required documentation. This time period shall not exceed three (3) months.

3. The S-SV EMS Agency shall establish the effective date of program approval in writing upon satisfactory documentation of compliance with all program requirements.

4. Paramedic training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years subject to the procedure for program approval specified in this policy.

G. Paramedic Training Program Review and Reporting:

1. All program materials specified in this policy shall be subject to periodic review by the S-SV EMS Agency and may also be reviewed upon request by the California EMS Authority.

2. All programs shall be subject to periodic on-site evaluation by the S-SV EMS Agency and may also be evaluated by the California EMS Authority.
3. Any person or agency conducting a training program shall notify the S-SV EMS Agency, in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in course objectives, hours of instruction, course director, program medical director, principal instructor, provisions for hospital clinical experience, or field internship.

H. Denial or Withdrawal of Paramedic Training Program Approval:

Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this policy, may result in denial, probation, suspension or revocation of program approval by the S-SV EMS Agency. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

1. The S-SV EMS Agency shall notify the approved paramedic training program course director in writing, by certified mail, of the provisions of this policy with which the paramedic training program is not in compliance.

2. Within fifteen (15) days of receipt of the notification of noncompliance, the approved paramedic training program shall submit in writing, by certified mail, to the S-SV EMS Agency one of the following:

   a. Evidence of compliance with the provisions of this policy, or

   b. A plan for meeting compliance with the provisions of this policy within sixty (60) days from the day of receipt of the notification of noncompliance.

3. Within fifteen (15) days of receipt of the response from the approved paramedic training program, or within thirty (30) days from the mailing date of the noncompliance notification if no response is received from the approved paramedic training program, the S-SV EMS Agency shall notify the California EMS Authority and the approved paramedic training program in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the paramedic training program approval.

4. If the S-SV EMS Agency decides to suspend or revoke the paramedic training program approval, the notification specified in subsection 3 of this section shall include the beginning and ending dates of the probation or suspension and the 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 S-SV EMS Agency’s letter of decision to the California EMS Authority and the paramedic training program.
I. Paramedic Student Eligibility:

1. To be eligible to enter a paramedic training program, an individual shall meet the following requirements:

   a. Possess a high school diploma or general education equivalent; and

   b. Possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association’s Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and

   c. Possess one of the following:

      - A current EMT certificate or NREMT-EMT registration; or
      - A current AEMT certificate in the State of California; or
      - Be currently registered as an EMT-Intermediate with the NREMT.

2. To be eligible to enter a CCP training program an individual shall be currently licensed, and accredited, in California as a paramedic with three (3) years of basic paramedic practice.

J. Paramedic Training Program Required Course Hours:

1. The total paramedic training program shall consist of not less than one thousand and ninety (1090) hours. These training hours shall be divided into:

   a. A minimum of four-hundred and fifty (450) hours of didactic instruction and skills laboratories;

   b. The hospital clinical training shall consist of no less than one-hundred and sixty (160) hours and the field internship shall consist of no less than four-hundred and eighty (480) hours.

2. The student shall have a minimum of forty (40) ALS patient contacts during the field internship as specified in the ‘Field Internship Education and Training for Paramedic’ subsection of this policy. An ALS patient contact shall be defined as the student performance of one or more ALS skills, except cardiac monitoring and CPR, on a patient.

3. The minimum hours shall not include the following:

   a. Course material designed to teach or test exclusively EMT knowledge or skills including CPR.

   b. Examination for student eligibility.
c. The teaching of any material not prescribed in the ‘Paramedic Training Program Required Course Content’ subsection of this policy.

d. Examination for paramedic licensure.

4. The total CCP training program shall consist of not less than two-hundred and two (202) hours. These training hours shall be divided into:

a. A minimum of one-hundred and eight (108) hours of didactic and skills laboratories; and

b. No less than ninety-four (94) hours of hospital clinical training as prescribed in the ‘Hospital Clinical Education and Training for Paramedic’ subsection of this policy.

K. Paramedic Training Program Required Course Content:

1. The content of a paramedic course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), to result in the paramedic being competent in the paramedic basic scope of practice specified in California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100146(a). The DOT HS 811 077A, can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address: http://www.ems.gov/education/nationalstandardandncs.html

2. The content of the CCP course shall include all items specified in California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100160(b).

L. Paramedic Training Program Required Testing:

1. Approved paramedic and CCP training programs shall include periodic examinations and final comprehensive competency-based examinations to test the knowledge and skills specified in this policy and current regulations.

2. Successful performance in the clinical and field setting shall be required prior to course completion.

M. Paramedic Training Program Course Completion Record:

1. Approved paramedic training program and/or CCP training program shall issue a tamper resistant course completion record to each person who has successfully completed the paramedic training program and/or CCP training program. The course completion record shall be issued no later than ten (10) working days from the date of the student’s successful completion of the paramedic training program and/or CCP training program.
2. The course completion record shall contain the following:
   a. The name of the individual.
   b. The date of completion.
   c. The following statement:
      • "The individual named on this record has successfully completed an
        approved paramedic training program", or
      • "The individual named on this record has successfully completed an
        approved Critical Care Paramedic training program"
   d. The name of the paramedic training program or CCP training program
      approving authority (S-SV EMS Agency), depending on the training
      program being taught.
   e. The signature of the course director.
   f. The name and location of the training program issuing the record.
   g. The following statement in bold print: "This is not a paramedic
      license."
   h. For paramedic training, a list of approved local optional scope of practice
      procedures and/or medications taught in the course.
   i. For CCP training, a list of procedures and medications specified in
      California Code of Regulations, Title 22, Division 9, Chapter 4, Section
      100146(c)(1)(S)(1-10) taught in the course.

NREMT PARAMEDIC TRANSITION COURSE REQUIREMENTS

A. NREMT paramedic transition courses shall only be taught by S-SV EMS Agency
   approved paramedic training programs.

B. Additional S-SV EMS Agency NREMT paramedic transition course training
   program approval is required and shall consist of verification of all requirements
   listed in this section of the policy.

C. Course curriculum shall be consistent with the “gap content” identified in the
   ‘National Association of State EMS Officials’ “National EMS Education
   Standards Transition Template”. This gap content can be accessed at the
   following website address:
D. NREMT paramedic transition course training programs shall ensure that their students complete the ICS-100, ICS-700, and HAZMAT First Responder Awareness level training (or the equivalent to these courses) either as prerequisites or co-requisites to the transition course.

E. The NREMT paramedic transition course shall consist of not less than 24 hours.

F. The NREMT paramedic transition course completion records shall include the following information on a tamper resistant document:

1. NREMT-Paramedic's name.
2. Transition course completion date.
3. The certificate must contain the following statement: "has completed a state approved EMT-Paramedic to Paramedic transition course".
4. Name of the sponsoring agency.
5. Signature of the individual responsible for the training.
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SUBJECT: VASCULAR ACCESS

PURPOSE:

To provide vascular access and fluid administration guidelines for Advanced EMT (AEMT) and Paramedic personnel.

AUTHORITY:

Health and Safety Code 1797.220 and 1798

California Code of Regulations, Title 22, Division 9, Chapters 3 & 4

POLICY:

A. Vascular Access Guidelines

1. Over-the-needle catheters may be inserted into peripheral veins of the limbs and external jugular vein for the following purposes:
   a. Administration of intravenous medications or fluid bolus
   b. Anticipated need to administer intravenous medications or fluid bolus

2. When large volumes of fluid may be required, large bore catheters (18-14 G) should be used, and placed in proximal veins when available. This includes, but is not limited to, patients requiring adenosine, STEMI and stroke patients, trauma patients, and patients in cardiac arrest.

3. Establish two (2) IV’s in patients who have, or are at risk for decompensation (e.g. hypovolemic shock)

4. Avoid more than three (3) attempts at vascular access per patient unless necessary for emergent treatment

5. Do not establish peripheral vascular access in the any extremity that has an existing dialysis shunt

6. Saline locks are optional and may be used when fluid boluses or numerous medication administrations are not expected to be necessary
7. A ‘fluid bolus’ in an adult patient consists of up to 1000 mL (unless otherwise specified in the applicable treatment protocol) of crystalloid solution delivered as rapidly as possible, with reassessment of hemodynamic parameters, respiratory status and lung sounds before and after administration.

8. A ‘fluid bolus’ in a pediatric patient consists of 20 mL/kg of crystalloid solution delivered as rapidly as possible, with reassessment of hemodynamic parameters, respiratory status and lung sounds before and after administration.

9. ‘TKO’ indicates a rate of 25-30 mL per hour (25-30 micro drops per minute, or 5 macro drops per minute). TKO shall be the default rate unless otherwise specified in the applicable treatment protocol.

B. External Jugular Vein Cannulation

1. External Jugular Vein Cannulation may be utilized in any situation where an IO would be acceptable.

2. Contraindications (Relative):
   a. Suspected coagulopathy (e.g. advanced liver disease or taking coumadin)
   b. Suspected cervical spine injury
   c. Inability to tolerate supine position
   d. Stable patient

3. Procedure:
   a. Place patient in trendelenburg (preferred) or supine position
   b. Elevate shoulders on a rolled towel or sheet
   c. Turn head 45 to 60 degrees to side opposite of intended venipuncture site
   d. Palpate to assure no pulsatile quality to vessel
   e. Prep venipuncture site with a recognized antiseptic agent and wipe dry with a sterile gauze pad
   f. “Tourniquet” vein by placing finger just above clavicle near midclavicular line
   g. Stabilize skin over vein with thumb
h. Point needle toward shoulder in direction of vein, and puncture vein midway between jaw and clavicle over belly of sternocleidomastoid muscle

i. Maintain compression of vein at clavicle area until needle is withdrawn and IV tubing has been connected in order to prevent air from entering vein

j. Secure IV site

4. Possible Complications:

a. Air embolism

b. Hematoma requiring compression of neck

c. Extravasation of fluid or medication, infection, thrombosis

C. Intraosseous Infusion

1. Indications:

a. Intraosseous infusion is indicated in emergency situations when life saving fluids or drugs should be administered and IV cannulation is difficult, impossible, or too time consuming to perform (e.g. if a peripheral IV cannot be established after two attempts or within 60-90 seconds of elapsed time)

b. For adult (paramedics only) and pediatric (paramedic or AEMT) patients, weighing 3 kg or more, who present with one or more of the following clinical conditions:
   - Cardiac arrest
   - Hemodynamic instability (B/P <90 mmHg and clinical signs of shock)
   - Imminent respiratory failure
   - Status epilepticus with prolonged seizure activity greater than 10 minutes, and refractory to IN/IM anticonvulsants
   - Toxic conditions requiring immediate IV access for antidote

   c. IO placement may be considered prior to peripheral IV attempts in cases of cardiopulmonary or traumatic arrest, in which it may be obvious that attempts at placing an IV would likely be unsuccessful or too time consuming, resulting in a delay of life-saving fluids or drugs
2. Contraindications:
   a. Fracture or suspected vascular compromise of the selected tibia or humerus
   b. Previous significant orthopedic procedures (IO within 24 hours; prosthesis)
   c. Inability to locate anatomical landmarks for insertion
   d. Skin infection overlying the area of insertion

3. Site Selection, Preparation and Insertion Notes:
   a. In small children (3-12 kg), the tibial tuberosity cannot be palpated as a landmark, so the insertion site is two finger-breadths below the patella in the flat aspect of the medial tibia

   b. In larger children (13-39 kg) the insertion site is located on the flat aspect of the medial tibia one finger-breadth below the level of the tibial tuberosity. If the tibial tuberosity is not palpable, insert two finger-breadths below the patella in the flat aspect of the medial tibia.

   c. For adults, proximal or distal tibial sites are preferred. If unavailable, the humeral site may be utilized as a site of last resort by providers who choose to approve their paramedic personnel to access this optional site:
      - The proximal tibial site is one finger-breadth medial to the tibial tuberosity
      - The distal tibial site is two finger-breadths above the medial malleolus (inner aspect of ankle) in the midline of the shaft of the tibia
      - Humeral insertion site is considered a site of last resort and may only be utilized by paramedic personnel who are adequately trained and approved by their prehospital provider agency to access this site
      - Prep the surface with a recognized antiseptic agent and wipe dry with a sterile gauze pad
      - Insert the device according to manufacture specific directions
      - Syringe flush catheter with 10 mL of normal saline. Remember, No Flush = No Flow. If the patient responds to painful stimuli, SLOWLY (over 1 to 2 minutes) administer 0.5 mg/kg of 2% Lidocaine (not to exceed 50 mg) prior to saline flush. Consider additional bolus of saline if flow rates slower than expected.
REFERENCE NO. 1101

SUBJECT: VASCULAR ACCESS

- Utilize a blood pressure cuff or pressure bag to help infuse fluids
- Dress site and secure tubing

4. Optional Secondary Humeral Insertion Site:
   a. Prehospital provider agencies may choose whether or not to allow their personnel to utilize the humerus as a secondary insertion site for adult patients who meet criteria for IO insertion and for whom utilization of the primary tibia insertion site is contraindicated
   b. Humeral insertion site selection:

   Expose the shoulder and place the patient’s arm against the patient’s body, resting the elbow on the stretcher or ground and the forearm resting on the abdomen. Note the humeral head on the anterior-superior aspect of the upper arm, or the anterior-lateral shoulder. Palpate and identify the mid-shaft humerus and continue palpating toward the proximal end (humeral head). Near the shoulder feel for the small protrusion, this is the base of the greater tubercle and the insertion site. With the opposite hand, pinch the anterior and inferior aspects of the humeral head, while confirming the identification of the greater tubercle. This will help ensure that you have located the midline of the humerus.
   c. Prehospital provider agencies choosing to utilize this optional insertion site will ensure that all of their paramedic personnel are adequately trained and approved to access this site

5. Precautions and Possible Complications:
   a. Chest compressions (if indicated), airway and breathing should be established first in accordance with other treatment protocols
   b. No more than one attempt in each tibia or humerus
   c. Local infiltration of fluids/drugs into the subcutaneous tissue due to improper needle placement
   d. Cessation of the infusion due to clotting in the needle, or the bevel of the needle being lodged against the posterior cortex
   e. Osteomyelitis or sepsis
   f. Fluid overload
   g. Fat or bone emboli
SUBJECT: VASCULAR ACCESS

h. Fracture

6. S-SV EMS Agency Approved IO Devices:

The following IO devices have been approved for use in the S-SV EMS Region:

a. Bone Injection Gun (B.I.G.®)

b. EZ-IO®

c. Manual IO device – bone marrow type needles, 15 and 18 gauge size

D. Preexisting Vascular Access Device (PVAD)

1. Paramedics may access pre-existing vascular devices on any patient who is in extremis and no other vascular access is available or appropriate. The types of catheters used are:

a. Indwelling catheter/device exiting externally inserted into the superior vena cava or right atrium (Broviac, Hickman, PICC and others)

b. Hemodialysis shunt (fistulas/grafts): used to divert blood flow from an artery to a vein

c. Internally implanted devices (Portacaths, etc.): access that is subcutaneous requiring entry through the skin and special equipment to access. These types of devices are Not approved for use by S-SV EMS personnel

2. Indications:

Only in the absence of any other observable vascular access, when the patient has:

a. Cardiopulmonary arrest

b. Extremis due to circulatory shock

c. Critical need for pharmacological intervention

3. Complications:

a. Infection: Due to the location of the catheter, strict adherence to aseptic technique is crucial when handling a PVAD

• Use of sterile gloves is recommended;
SUBJECT: VASCULAR ACCESS

- Prep injectable port and surrounding skin with chlorhexidine prior to attaching I.V. tubing;
- Use new supplies if equipment becomes contaminated;
- Re-cover port with sterile dressing and securely tape.

b. Air Embolism: The PVAD provides a direct line into the central circulation; introduction of air into these devices can be hazardous

4. Approved Infusions:
   a. Intravenous solutions
   b. All medications except diazepam (Valium) as it interacts with silicone causing crystallization of the medications and deterioration of the silicone

5. Procedure:
   a. Do not remove injection cap from catheter
   b. Do not use a syringe smaller than 10 ml to prevent catheter damage from excess infusion pressure
   c. Always expel air from syringe prior to administration
   d. Follow all medications with 5 ml of saline to avoid clots
   e. Do not inject medications or fluids if resistance is met when establishing patency
   f. Do not allow I.V. fluids to run dry
   g. Do not manipulate or remove an indwelling catheter under any circumstances
   h. Should damage occur to the external catheter, clamp immediately between the skin exit site and the damaged area to prevent air embolism or blood loss
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PURPOSE:

To define the indications and use of CO-Oximeter devices in the prehospital setting by paramedic personnel.

AUTHORITY:

Health and Safety Code 1797.220 and 1798

California Code of Regulations, Title 22, Division 9, Chapter 4

OVERVIEW:

As carbon monoxide (CO) is considered the “silent killer”, its presence should be considered on the fire ground, in confined spaces, when multiple unexplained illnesses occur within the same occupancy, or when a CO detector has alarmed.

CO is only slightly lighter than air and usually rises to the ceiling with the warm currents of air blown into a house. Because its specific gravity is so close to that of air, it blends quickly with a home’s atmosphere and is quite pervasive. A typical home can be charged within minutes with lethal levels of CO by a malfunctioning forced air furnace. This silent killer is particularly adept at killing those in their sleep, as they tend to succumb without any waking symptoms.

CO has an affinity with hemoglobin, the oxygen carriers of the blood, which is 250 times greater than that of oxygen. The hemoglobin becomes saturated with CO, like a magnet, replacing oxygen molecules and greatly reducing available oxygen to the cells of the body – particularly the brain.

INDICATIONS:

The use of CO-Oximeters to measure CO exposure is an advanced life support skill because it is considered a laboratory test rather than a measurement of vital signs.

S-SV EMS paramedic personnel may utilize an approved CO-Oximeter as a laboratory testing device on any patient (adult and pediatric) with suspected carbon monoxide (CO) exposure.
**Signs & Symptoms of Possible CO exposure**

The initial symptoms of CO exposure are insidious, similar to the flu and thus seemingly benign. These symptoms increase in severity as the SpCO level rises and may include:

1. Dizziness/vertigo
2. Headache
3. Shortness of breath
4. Nausea/vomiting
5. Fatigue
6. Confusion/altered judgment
7. Syncope
8. Tachycardia
9. Cardiac arrhythmias
10. Seizures
11. Shock
12. Coma
13. Apnea

**PROCEDURE:**

A. All persons entering areas of suspected elevated CO levels should don appropriate PPE, including, but not limited to SCBA.

B. Remove all ambulatory persons/patients to fresh air as soon as safely permitted. Remaining patients should be triaged and extricated according to START-TRIAGE procedures.

C. Secondary triage including application of the CO-Oximeter away from the CO source in accordance with the accompanying algorithm will allow for determination of further treatment and transport considerations.

D. Approved triage tags should be used when necessary with CO level, time measured, and time O2 applied recorded on the triage tag along with standard information.

E. Use of the CO-Oximeter should not interfere with treatment or transport of any other suspected or identified injury or illness nor does it negate the need for further management and investigation of the symptomatic patient as other medical conditions may still be present.

F. The following guidelines should be utilized regarding placement of the CO-Oximeter finger sensor:

   1. Sensor should be placed on the middle or ring finger. Index finger may be used, but as a last choice.
2. Thumb placement may be utilized for patients 10 – 50 kg.

3. Sensor should not be below heart level.

4. Insert finger until the tip of finger hits the “Stop Block”, LED’s (red light) should pass through mid-nail, not cuticle.

CARBON MONOXIDE (CO) EXPOSURE ASSESSMENT AND TRIAGE ALGORITHM:

Patients with the following SpCO measurements should be considered critical and require treatment with 100% O₂ and immediate rapid transport to the closest facility
- > 25% in Adults
- > 15% in Pediatrics or Pregnant Females

- Measure SpCO with CO-Oximeter device

0 – 3%
- Considered a normal reading
- Treat according to appropriate protocol based on patient presentation

3 – 12%
- Symptoms of CO exposure?
  - YES
    - 100% O₂
    - Treat according to General Medical Protocol M-6 or other appropriate protocol based on patient presentation
    - Transport to closest facility
  - NO
    - No further evaluation of SpCO needed
    - Treat according to appropriate protocol based on patient presentation
    - Contact base/modified base hospital if additional assistance is required

> 12%
- 100% O₂
- Treat according to General Medical Protocol M-6 or other appropriate protocol based on patient presentation
- Transport to closest facility

Contact Receiving Hospital
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REMOVE

Policy

1106
SKILLS COMPETENCY/REGIONAL TRAINING MODULE VERIFICATION SUMMARY

LALS/ALS PROVIDER AGENCY _____________________________________________

NAME ___________________________          CALENDAR YEAR ________________

AEMT CERTIFICATION #/PARAMEDIC LICENSE # ________________________________

REGIONAL TRAINING MODULE COMPLETION DATE ______________________________

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Updated 06/13
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INTRAOSSEOUS INFUSION ANNUAL SKILLS VERIFICATION - MANUAL

NAME ___________________________________             DATE ____________________________________
ALS AGENCY ____________________________             EVALUATOR ______________________________

OBJECTIVE: The candidate will demonstrate the ability to correctly insert a manual intraosseous needle in a pediatric patient, check for proper needle placement, stabilize the needle, and administer fluid.

EQUIPMENT: Intraosseous needle, IO manikin or long bone (such as a tibia) from chicken or other animal, gauze roller bandage or other material to maintain proper position of long bone, flush solution, IV solution, IV administration set, three-way stopcock, blood pressure cuff or pressure bag appropriate syringes, recognized antiseptic agent, appropriate PPE.

PERFORMANCE CRITERIA AND CONDITIONS: The candidate will be presented with a long bone and requested to initiate an intraosseous infusion.

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<thead>
<tr>
<th>EVENT</th>
<th>DOES</th>
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<tbody>
<tr>
<td>1. States the indications for intraosseous infusion in a pediatric patient</td>
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<td>• Weight 3 kg or more</td>
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<td>• Unable to achieve IV access rapidly (within 60-90 seconds) and present with one or more of the following conditions:</td>
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<td>o Cardiac Arrest</td>
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<td>o Hemodynamic instability (SBP &lt; 90 &amp; signs of shock)</td>
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<td>o Imminent respiratory failure</td>
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<td>o Status epilepticus with prolonged seizure activity &gt; 10 minutes and refractory to IM/IN anticonvulsants</td>
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<td>o Toxic conditions requiring immediate IV access for antidote</td>
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<td>2. States the contraindications for intraosseous infusion</td>
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<td>• Fracture or suspected vascular compromise of the selected tibia</td>
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<td>• Previous significant orthopedic procedures (IO within previous 24 hours; prosthesis)</td>
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<td>• Inability to locate anatomical landmarks for insertion</td>
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<td>• Skin infection overlying the area of insertion</td>
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<td>3. States or demonstrates the use of PPE</td>
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<td>4. Assembles equipment and fills syringe with flush solution (if necessary)</td>
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<td>5. Selects proper/approved anatomical site for IO infusion</td>
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<td>• 1 – 3 cm distal to tibial tuberosity on anteromedial surface of proximal tibia</td>
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<td>6. Prep IO site using aseptic technique</td>
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## INTRAOSSEOUS INFUSION ANNUAL SKILLS VERIFICATION (MANUAL PEDIATRIC) – Cont.

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<tr>
<th>EVENT</th>
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<tr>
<td>7. Inserts IO needle at the proximal tibial site, directing the needle caudally</td>
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<td>8. Penetrates the bone with firm pressure and a rotary (&quot;screwdriver&quot;) motion. Identifies a “pop” and a sudden lack of resistance signaling</td>
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<td>9. Stabilizes device, removes stylet and places in sharps container</td>
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<td>10. Attaches syringe and aspirates for marrow contents and / or slowly infuses 2 – 3 ml of NS while observing the site for absence of infiltration to confirm patency</td>
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<td>11. Administers 0.5 mg/kg of 2% lidocaine (not to exceed 50 mg) if patient responds to painful stimuli (may be verbalized)</td>
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<td>12. Syringe flushes catheter with 10 ml of NS to establish infusion (No Flush = No Flow)</td>
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<td>13. Attaches IV administration set and administers proper fluid by applying pressure to the fluid bag</td>
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<td>14. Properly secures device</td>
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<td>15. Checks administration rate and IO site for infiltration</td>
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