MEMORANDUM

DATE: November 1, 2010

TO: Subscribers to the Sierra-Sacramento Valley EMS Agency Prehospital Care Policy Manual

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

SUBJECT: S-SV EMS AGENCY PREHOSPITAL CARE POLICY MANUAL UPDATE #45

EFFECTIVE DATE OF IMPLEMENTATION – December 1, 2010

Enclosed is Change Notice #45 for the S-SV Prehospital Care Policy Manual.

Prior to implementation of these Polices/Protocols:

- Service providers are responsible for distribution of policies and protocols to BLS/LALS/ALS personnel.
- Service providers will provide orientation to BLS/LALS/ALS personnel regarding the provisions and requirements of new policies and protocols.
- Base/Modified Base Hospital Medical Directors and Base/Modified Base Hospital Coordinators are also responsible for providing orientation to emergency department physicians and nursing personnel.
- Please note that the LALS (Advanced EMT) updated treatment protocols will not be included with this update packet to avoid confusion. These protocols will be provided separately to the provider agencies that utilize Advanced EMT personnel as well as their base hospitals. These updated policies will also be posted on our website.

Please advise all prehospital and base hospital personnel that S-SV policies/protocols have the approval of S-SV EMS Agency committees, Regional Executive Director and the Medical Director. Therefore, all policies/procedures shall be strictly adhered to and are the basis for CQI activities. Deviations from these written policies should be reported to the S-SV EMS Agency.

S-SV EMS Agency website at www.ssvems.com
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<td>S-SV EMS Regional Medical Control Advisory Committee Bylaws</td>
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<td>S-SV EMS Agency Regional STEMI Continuous Quality Improvement Committee Bylaws</td>
<td>Add</td>
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<td>Paramedic Interfacility Transport Optional Skills: Transferring Hospital Requirements</td>
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<td>Addition of pre-existing blood transfusions and magnesium sulfate infusions as approved paramedic IFT optional skills</td>
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<td>9-1-1 Ambulance Response Time Criteria</td>
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<td>Updated with Butte &amp; Colusa County response time calculation flowcharts. Additional language regarding use of paramedic supervisor personnel to stop the response time clock when allowed</td>
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<td>9-1-1 Response Time Criteria - Nevada County</td>
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<td>Updated response times for Truckee Fire Protection District</td>
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<td>9-1-1 Response Time Criteria - Colusa County</td>
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<td>9-1-1 Response Time Criteria - Butte County</td>
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<td>Paramedic Administered Influenza Vaccinations</td>
<td>Remove</td>
<td>EMSA policy approval expiration date effective 07/01/2010. Policy is no longer approved</td>
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<td>Paramedic Interfacility Transport Optional Skills: Service Provider Requirements &amp; Responsibilities</td>
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<td>Paramedic Interfacility Transport Optional Skills: Application and Approval Process</td>
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<td>Paramedic Interfacility Transport Optional Skills: Service Provider Application</td>
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<td>505-A</td>
<td>S-SV EMS Base / Receiving Hospital Capabilities Addendum</td>
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<td>Updated with Control Facility (CF) information previously located in policy 837</td>
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<td>Stroke System Triage &amp; Patient Destination</td>
<td>Add</td>
<td>New policy regarding stroke system triage and patient destination</td>
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<td>ALS Service Provider Inventory</td>
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<td>Updated to add Field Operations Guide (FOG), chlorhexidine, decrease naloxone and glucagon minimum quantities, and to add commercial tourniquet devices as an optional item</td>
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<td>LALS (Advanced EMT) Service Provider Inventory</td>
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<td>Emergency Medical Responder (EMR) Scope of Practice</td>
<td>Add</td>
<td>New scope of practice policy for EMR personnel</td>
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<td>Hazardous Materials Incidents</td>
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<td>Updated Haz Mat policy - additional clarification under the 'Scene Management' section. Addition of CHEMPACK resource reference</td>
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<td>Multiple Patients/Casualty Incidents</td>
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<td>Updated to incorporate new S-SV EMS counties as well as LEMSA HPP consultant. List of Control Facilities moved to 505-A</td>
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<td>837-A,B, and C</td>
<td>MCI Response Procedures, Organizational Chart, and Position Responsibilities</td>
<td>Add</td>
<td>New addendums to policy 837 to incorporate recommendations from LEMSA HPP consultant</td>
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<td>Intravenous Infusion of Magnesium Sulfate, Nitroglycerine, Heparin &amp;/or Amiodarone During Interfacility Transports</td>
<td>Replace</td>
<td>Addition of magnesium sulfate infusions. Updated language regarding transfer of emergent patients needing critical interventions</td>
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<td>Monitoring of Pre-Existing Blood Transfusion During Interfacility Transports</td>
<td>Add</td>
<td>New policy allowing monitoring of blood transfusions as an approved paramedic IFT optional skill</td>
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<td>Patient Initiated Released at Scene (RAS) or Patient Initiated Refusal of Service Against Medical Advice (AMA)</td>
<td>Replace</td>
<td>Updated policy language to allow BLS personnel to complete an RAS / AMA and to address communication failure issues</td>
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<td>850-A</td>
<td>S-SV EMS Refusal of Care Form</td>
<td>Add</td>
<td>New reference document / form for policy 850</td>
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<td>R-3</td>
<td>Acute Respiratory Distress</td>
<td>Replace</td>
<td>Moved CPAP up in to the BLS box in the algorithm / clarified use of CPAP for moderate - severe respiratory distress. Administration route of epinephrine 1:1,000 changed to IM, thigh preferred</td>
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<td>R-3 (LALS)</td>
<td>Acute Respiratory Distress (LALS - Advanced EMTs)</td>
<td>Replace</td>
<td>Added CPAP to the BLS box in the algorithm / clarified use of CPAP for moderate - severe respiratory distress. Administration route of epinephrine 1:1,000 changed to IM, thigh preferred</td>
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<td>M-5</td>
<td>Ingestions &amp; Overdoses</td>
<td>Replace</td>
<td>Clarification that activated charcoal administration is a base / modified base hospital order. Removal of atropine, glucagon, and epinephrine from the Calcium Channel Blockers treatment algorithm. Decreased glucagon dose from 2 mg to 1 mg in the Beta Blockers treatment algorithm</td>
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<td>M-5 (LALS)</td>
<td>Ingestions &amp; Overdoses (LALS - Advanced EMTs)</td>
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<td>Suspected CVA / Stroke</td>
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<td>Cold Stress Emergencies: Hypothermia</td>
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<td>Added &quot;No&quot; to the arrow under &quot;V Tach or V fib?&quot; diamond. Added note for &quot;warm&quot; fluid bolus if available</td>
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<td>E-2 (LALS)</td>
<td>Cold Stress Emergencies: Hypothermia (LALS - Advanced EMTs)</td>
<td>Replace</td>
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<td>Hazardous Material Exposure</td>
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<td>E-7 (LALS)</td>
<td>Hazardous Material Exposure</td>
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<td>Isolated Extremity Injury - Including Hip or Shoulder Injuries</td>
<td>Replace</td>
<td>Clarification regarding administration of morphine and midazolam. Addition of reference to new policy T-8</td>
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<td>T-8</td>
<td>Uncontrolled Extremity Bleeding</td>
<td>Add</td>
<td>New policy regarding the use of approved commercial tourniquet devices (optional) for patients with uncontrolled extremity bleeding</td>
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<td>P-2</td>
<td>Neonatal Resuscitation - Infants ≤ 28 Days Old</td>
<td>Replace</td>
<td>Typographical error correction clarifying epinephrine concentration</td>
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<td>P-2 (LALS)</td>
<td>Neonatal Resuscitation - Infants ≤ 28 Days Old</td>
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<td>Respiratory Distress - Wheezing (Lower Airway: Asthma)</td>
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<td>Respiratory Distress - Wheezing (Lower Airway: Asthma) - (LALS - Advanced EMTs)</td>
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<td>P-18</td>
<td>Allergic Reaction / Anaphylaxis</td>
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<td>Change in administration route of epinephrine 1:1,000 from SQ to IM - thigh preferred</td>
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<td>Altered Level of Consciousness</td>
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<td>Isolated Extremity Injury - Including Hip or Shoulder Injuries</td>
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<td>Uncontrolled Extremity Bleeding - Pediatric</td>
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<td>EMT Certification and Recertification</td>
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<td>Correction of error on page 8 of 9 under 'Recertification After Lapse in Certification'. For a lapse of twelve (12) months or more, but less than twenty-four (24) months, applicant is required to complete an additional twenty-four (24) hours of continuing education for a total of forty-eight (48) hours of training</td>
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<td>Paramedic Accreditation to Practice</td>
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<td>Updated minor language regarding accreditation expiration dates and information regarding field evaluation contacts</td>
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<td>Paramedic Employee Status Report</td>
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<td>New policy for requirements and approval process of EMR training programs</td>
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### SECTION IV

**PROVIDER AGENCIES**

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<td>Service Provider: Application Process &amp; Procedure for Approval / Renewal, Denial, Suspension, Revocation and Appeals Process</td>
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<td>Basic Life Support Service Provider Policy &amp; Application for Special Events &amp; Standbys</td>
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<td>9-1-1 Provider Response Policy</td>
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<td>Fireline Paramedic Programs</td>
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<td>EMT / Public Safety AED Program: Service Provider Requirements &amp; Responsibilities</td>
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<td>AED Annual Program Update Form</td>
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<td>AED Skills Check Documentation Record</td>
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<td>AED Program: By Lay Rescuer Personnel</td>
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<td>EMT Optional Skill: Service Provider Application, Approval Process, Requirements and Responsibilities</td>
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**SECTION V**

**RECEIVING HOSPITAL / PATIENT DESTINATION**

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<td>Stroke System Triage &amp; Patient Destination</td>
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<td>Emergency Department Downgrade and/or Cessation</td>
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**SECTION VI**

**RECORD KEEPING / AUDIT / QUALITY IMPROVEMENT**

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12/01/2010
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**Medical**

M-1  Allergic Reaction / Anaphylaxis
M-2  Shock / Non-Traumatic Hypovolemia
M-5  Ingestions & Overdoses
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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Sierra-Sacramento Valley EMS Agency

JOINT POWERS GOVERNING BOARD OF DIRECTORS

VICTORIA PINETTE
Regional Executive Director

TROY FALCK, MD
Medical Director

KAREN CRAIN-RIDDLE, RN
Associate Director/QI

JOHN LORD, RN
Associate Director

GEOFFREY PEABODY, II
Information Technology Analyst

LINDA COMBS
Data Analyst

KRISTY HARLAN
Contract Compliance

RON GRIDER
Regional Disaster Medical Health Specialist

SHAWN JOYCE
Emergency Preparedness Coordinator/PIO

DIANA NOLASCO
Administrative Secretary

OPEN
EMS Specialist

JOHN POLAND, EMT-P
QI/Education Coordinator

OPEN
Records Analyst

OPEN
Clerical

As of AUGUST 2010
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Sierra-Sacramento Valley
Emergency Medical Services Agency
Regional Medical Control Advisory Committee

BYLAWS

ARTICLE I

NAME

SECTION 1. The Committee shall be referred to as the Regional Medical Control Advisory Committee.

SECTION 2. The Committee shall be governed by Robert’s Rules of Order.

ARTICLE II

PURPOSES

SECTION 1. The purposes of the Committee shall be to:

A. Represent the position of base hospitals and ALS service provider agencies on prehospital care and emergency medical services issues, as may be deemed necessary.

B. Promote communication and coordination among all interested parties for effective response to determine needs of prehospital care.

C. Promote region-wide standardization of prehospital care policies, procedures and protocols.

D. Recommend policies, procedures, protocols, positions, and philosophy of prehospital care and standards of care to the Sierra-Sacramento Valley Emergency Medical Services (S-SV EMS) Agency.

ARTICLE III

AUTHORITY

SECTION 1. AUTHORITY

A. The Committee shall function as advisory to the S-SV EMS Agency.

B. The Agency shall inform the committee, at the next regularly scheduled meeting, of any committee recommendation that is overruled or modified and provide details of the reversal or modification.
ARTICLE IV
MEMBERSHIP

SECTION 1. MEMBERS

A. Membership:

The Committee shall consist of the following members:

1. The base/modified base hospital medical director, or the base/modified base hospital's appointed physician representative, from each S-SV base/modified base or trauma base hospital.

2. The base/modified base hospital coordinator, or the base/modified base hospital's appointed nursing representative, from each S-SV base/modified base or trauma base hospital.

3. One (1) public ALS service provider paramedic representative and one private ALS service provider paramedic representative, who actively practice in the field, from the following two S-SV EMS Region county groups:
   - Colusa, Nevada, Placer, Sutter, Yolo and Yuba Counties
   - Butte, Shasta, Siskiyou and Tehama Counties

   The committee will appoint the above paramedic representatives through nominations received from S-SV hospital and prehospital service provider agencies.

   In the event that there are no public paramedic representatives available or nominated from one or both county groups, the committee may choose to appoint another prehospital representative (Advanced EMT or EMT) for that area using a similar nomination process.

4. The Emergency Department Medical Director, or the appointed physician or nursing representative from each S-SV receiving hospital that is located within the S-SV region.

5. One (1) appointed member from each active S-SV county EMCC committee. This member may alternately be appointed by the EMS committee if the county does not have an EMCC committee.
B. Ex-officio - non-voting membership:

The Committee ex-officio, non-voting, membership shall consist of representative(s) from hospitals, located outside of the S-SV region, which provide specialty care services for the S-SV region.

SECTION 2. APPOINTMENT AND TERM

A. Base/modified base/receiving hospital members are appointed by their hospital and serve at the request of the S-SV EMS Agency until:

1. Resignation
2. Replacement
3. Removal

B. Paramedic/prehospital members are appointed by the committee and serve for a term of one year from July 1 through June 30, or until:

1. Resignation
2. Replacement
3. Removal

C. EMCC/county members are appointed by their county EMCC or EMS committee and serve at the request of the S-SV EMS Agency until:

1. Resignation
2. Replacement
3. Removal

SECTION 3. VOTING

A. Each base/modified base or trauma base hospital represented shall have one (1) vote.

B. Each receiving hospital represented shall have one (1) vote.

C. Each paramedic/prehospital member shall have one (1) vote.

D. Each EMCC / EMS committee member shall have one (1) vote.

E. Votes shall be recorded as:

1. In Favor
2. Opposed
3. Abstain
SECTION 4. ATTENDANCE

A. Members are expected to attend all meetings of the Committee.

B. Absence

1. Absence is defined as failure of the member to notify the committee’s Chairperson or the S-SV EMS Agency prior to the meeting.

2. Absences are grounds for removal from the member Committee.

3. Absence shall not be counted if the member's alternate is present.

C. Alternates

Alternates shall be appointed to the Committee by the S-SV EMS Agency. This will be done in a consultation and in consensus with the member. In absence of the member, the alternate shall assume the duties and responsibilities of the member.

SECTION 5. REMOVAL

The following are reasons for removal of a member or alternate from the Committee:

A. Excessive Absence

B. Disruption and/or rude behavior

C. Lack of participation and/or work product

D. Violation of Bylaws

ARTICLE V

OFFICERS

SECTION 1. OFFICERS

A. The Committee shall elect a Chairperson and a Vice-Chairperson.

B. Election of officers shall occur yearly and the term of office shall be July 1 through June 30.
SECTION 2. RESPONSIBILITY OF OFFICERS

A. The Chairperson shall preside over committee meetings.

B. The Chairperson shall participate in the preparation of the agenda for each committee meeting.

C. The Vice Chairperson shall assume the responsibilities of the Chairperson in the absence of the Chairperson.

SECTION 3. ELECTIONS

A. Elections shall be held yearly at the June Committee meeting, and whenever a vacancy of office occurs.

B. Nominations for officers are requested by the Chairperson in April and accepted until the election. Any member may nominate any other member. The member nominated must accept the nomination in order for the nomination to be valid.

C. Committee members shall elect the committee officers by a majority vote during the June meeting.

SECTION 4. VACANCIES

A. If the Chairperson should vacate the office during the term, the Vice Chairperson shall become Chairperson and preside over the elections of a new Vice Chairperson.

B. If the Vice Chairperson should vacate the office, the Chairperson shall preside over the election process.

ARTICLE VI

BUSINESS

SECTION 1. QUORUM

A Quorum shall consist of fifty-one percent (51%) of Committee member votes. Business of the Committee shall not be conducted unless a quorum is present.

SECTION 2. BYLAWS

A bylaw’s change requires that the recommended change is placed on the agenda as a non-action item. At the next committee meeting, the bylaws may be recommended for change by a two-thirds (b) vote. All bylaw changes require
approval of the S-SV EMS Agency.

**ARTICLE VII**  
**S-SV EMS AGENCY**

The S-SV EMS Agency volunteers to perform the following functions to assist the committee:

**SECTION 1. REPRESENTATION**

A. A representative of the S-SV EMS Agency staff shall be present at each committee meeting.

B. S-SV EMS Agency representative(s) are non-voting member(s) of the committee.

C. The representative(s) shall have the right to be heard before the committee on any matter on the agenda, after being recognized by the Chairperson.

**SECTION 2. RESPONSIBILITIES OF S-SV EMS AGENCY**

The S-SV EMS Agency shall:

A. In consultation with the Chairperson, establish the agenda.

B. Record the proceedings and prepare the meeting minutes.

C. Maintain the committee records including: an updated list of members and officers, member contact information, a copy of the Bylaws and a file of all meeting minutes.

D. Distribute the meeting notice and any other committee correspondence.

**ARTICLE VIII**  
**EFFECTIVE DATE**

These Bylaws shall be effective upon approval by the COMMITTEE.

Approved SIGNATURE ON FILE Date: 10/20/2010
1. NAME

This Committee shall be referred to as the REGIONAL STEMI CONTINUOUS QUALITY IMPROVEMENT COMMITTEE, hereinafter referred to as the “COMMITTEE”.

2. IMPLEMENTATION AUTHORITY

A. The COMMITTEE is established by the Medical Director of the Sierra-Sacramento Valley Emergency Services Agency (AGENCY) as an advisory committee to the AGENCY. The AGENCY is a Multi-County Joint Powers Agency responsible to receive hospital and service provider input and direction specific to STEMI patient emergency medical care in the JPA region.

B. The COMMITTEE is created pursuant to the requirements of California Health and Safety Code Section 1157.7 and California Code of Regulations, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 12, EMS System Quality Improvement.

3. DEFINITIONS

“Emergency Medical Services System Quality Improvement Program” (or EMS QI Program) refers to 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 those causes, and take steps to correct the process and recognize excellence in performance and delivery of patient care.

4. STATEMENT OF PURPOSE

A. To promote region-wide standardization of STEMI patient continuous quality improvement.

B. To monitor, evaluate and report on quality of training, care and transportation, including compliance with laws, regulations, policies and procedures and recommend revisions and/or corrective action as necessary.

C. To make recommendations specific to EMS provider, hospital and AGENCY data collection and dissemination.
5. **DUTIES**

   A. Participate with AGENCY in monitoring, collecting data on, and evaluating STEMI patient identification, treatment and transport from the EMS providers and hospitals within the AGENCY’s jurisdiction.

   B. Re-evaluate, expand upon, and revise as needed, locally developed indicators used by the COMMITTEE for STEMI patient quality improvement.

   C. AGENCY will provide a follow-up status report to the COMMITTEE on all cases presented until the case CQI loop is closed.

   D. All patient care records and other confidential materials will be returned to the AGENCY at the end of the meeting.

6. **MEMBERSHIP**

   VOTING MEMBERSHIP will include the following representatives from the AGENCY’s region:

   A. One Cardiac Catheterization Laboratory Physician Medical Director from each AGENCY designated STEMI Receiving Center.

   B. One emergency department physician or RN representative from each AGENCY designated STEMI Receiving Center.

   C. One quality improvement representative (Paramedic or RN) from each AGENCY contracted ALS 9-1-1 ground transport service provider within the catchment area of an AGENCY designated STEMI Receiving Center.

   D. One quality improvement representative (Paramedic or RN) from each AGENCY approved ALS public EMS provider within the catchment area of an AGENCY designated STEMI Receiving Center.

   Each Member shall have an alternate available to assume the member’s responsibility in their absence. Cardiac Catheterization Laboratory alternates may be another physician, a Registered Nurse (RN), or a Registered Cardiovascular Invasive Specialist (RCIS).

   NON-VOTING MEMBERSHIP will include representatives of the AGENCY. In addition, any representative from the categories listed above may attend meetings if confidentiality requirements are met.

7. **OFFICERS**

   The COMMITTEE shall elect a Chair and Vice-Chair.

8. **TERMS**

   A. Officers shall be elected by the COMMITTEE for yearly terms commencing July 1 through June 30th.
B. If the Chair’s office is vacated prior to the term’s end, the Vice-Chair will assume the duties for the remainder of the term and a new Vice-Chair will be elected.

C. If the Vice-Chair’s office is vacated prior to term’s end, a replacement will be elected.

D. Members shall serve at the will of the COMMITTEE, or until removed, resigned or replaced.

E. Members who are unable to attend a regularly scheduled meeting should notify the AGENCY of their absence prior to the meeting and should send an alternate in their place.

9. MEETINGS, VOTING, QUORUM

A. Meetings shall be held no less than two (2) times in a calendar year. Meeting dates and times to be set or modified as agreed to by COMMITTEE.

B. Special meetings may be called by the AGENCY Medical Director or the Chair as appropriate or upon written request of a majority of COMMITTEE members.

C. A quorum to conduct business shall consist of three eligible voting members.

D. The Chair will preside over meetings and participate with the AGENCY in the preparation of the agenda.

E. Meetings will be conducted in a fair and professional manner.

F. The COMMITTEE shall operate under commonly accepted parliamentary procedures and Robert’s Rules of Order shall govern the conduct of meetings when applicable.

G. Votes shall be recorded as:
   - In Favor
   - Opposed
   - Abstain

H. The AGENCY will be responsible for preparing the Agenda and taking and maintaining minutes.

10. AMENDMENT OF BYLAWS

Any rule or procedure of the COMMITTEE may be enacted, amended, repealed or suspended by a majority vote of the total voting membership.

11. CONFLICT OF INTEREST

Members and officers shall disclose any direct personal or pecuniary (monetary) interest in any subject or conversation before the COMMITTEE and will abstain from voting on any motion relative to that subject.
12. CONFIDENTIALITY

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The COMMITTEE’S 1157.7 business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.

Members and attendees will sign a statement of confidentiality as a condition of participation.

13. EFFECTIVE DATE

These Bylaws shall be effective upon approval by the COMMITTEE.

Approved _______________ SIGNATURE ON FILE Date: __8/13/2010______
SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS: TRANSFERING HOSPITAL REQUIREMENTS

PURPOSE:

To provide a mechanism for paramedics to be permitted to monitor and/or use any of the following during interfacility transfers:

A. Blood transfusions

B. Magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions

C. Automatic Transport Ventilators (ATV’s)

AUTHORITY:


California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

A. Only those paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director on interfacility transport optional skills will be permitted to utilize such skills during interfacility transports.

B. Only those ALS ambulance providers approved by the S-SV EMS Agency Medical Director will be permitted to provide the services of interfacility optional skills during interfacility transports.

C. Patients that are candidates for paramedic transport will have the following as indicated:

1. Blood Transfusions

   Pre-existing blood transfusions in peripheral or central IV lines.
2. Magnesium Sulfate, Nitroglycerin, Heparin and/or Amiodarone Infusions
   a. Pre-existing magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions in peripheral or central IV lines.
   b. The nitroglycerin, heparin and/or amiodarone infusion will have been running for at least 30 minutes prior to transport.
   c. Magnesium sulfate infusions are only approved for patients with suspected pre-eclampsia.

3. Automatic Transport Ventilators
   Paramedics shall not initiate ventilator support.

PROCEDURE

A. The transferring hospital shall ensure the paramedic receives transferring orders from the transferring physician prior to leaving the sending hospital. These orders will include a telephone number where the transferring physician can be reached during transport in addition to the following as indicated:

1. Blood Transfusions
   a. Blood type and unit identifying number.
   b. Parameters for regulation of the transfusion rate.

2. Magnesium Sulfate, Nitroglycerin, Heparin and/or Amiodarone Infusions
   a. Type of solution.
   b. Dosage and rate of infusion.

3. Automatic Transport Ventilators
   a. Parameters for maintaining and adjusting ventilations during transport.

B. The transferring hospital is responsible for mixing and labeling the magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions. If the existing infusion will not be sufficient for transport, then the hospital must provide additional pre-mixed infusion that is clearly labeled.

C. Transferring physicians must be aware of the general scope of practice of paramedics and transport parameters outlined in Policy # 841, #842 and #843.
SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS:
TRANSFERRING HOSPITAL REQUIREMENTS

CROSS REFERENCES:

Prehospital Care Policy Manual

Paramedic Interfacility Transport Optional Skills: Service Provider Requirements & Responsibilities, Reference No. 441

Paramedic Interfacility Transport Optional Skills: Application and Approval Process, Reference No. 442

Intravenous Infusion of Magnesium Sulfate, Nitroglycerin, Heparin &/or Amiodarone During Interfacility Transports, Reference No. 841

Automatic Transport Ventilators During Interfacility Transports, Reference No. 842

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SIERRA-SACRAMENTO VALLEY EMS AGENCY

PROVIDER AGENCIES
SECTION IV

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REFERENCE NO. 400

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475  EMT/Public Safety AED Program: Application & Approval Process

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477-A  EMT Optional Skill - Service Provider Application Form

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 415

SUBJECT: 9-1-1 AMBULANCE RESPONSE TIME CRITERIA

PURPOSE:

To establish response time standards and reporting criteria for all transporting 9-1-1 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 9-1-1 ALS ambulance unit has been notified of a request for 9-1-1 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.

Effective Date: 12/01/2010
Next Review Date: 09/2013
Approved:

Date last Reviewed / Revised: 09/10
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SUBJECT: 9-1-1 AMBULANCE RESPONSE TIME CRITERIA

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 9-1-1 call is first received and/or transferred.

PSAP Notification Time – The point in time when a 9-1-1 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 9-1-1 ambulance provider. See Policy section, item C.

Response Time Compliance Report – Report submitted monthly to S-SV EMS Agency by all transporting 9-1-1 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. 9-1-1 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

**American Medical Response – Yolo 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

**North Tahoe Fire Protection District**

- PSAP
- North Tahoe Ambulance Unit
- On Scene

**Penn Valley Fire District**

- PSAP
- Secondary PSAP
- Penn Valley Ambulance Unit
- On Scene
SUBJECT: 9-1-1 AMBULANCE RESPONSE TIME CRITERIA

Sierra Nevada Ambulance

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

Response Time Clock Starts Here → Response Time Clock Ends Here

South Placer Fire Protection District

PSAP → Secondary PSAP → South Placer Fire Ambulance Unit → On Scene

Response Time Clock Starts Here → Response Time Clock Ends Here

Truckee Fire Protection District

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

Response Time Clock Starts Here → Response Time Clock Ends Here

Enloe Ambulance – Colusa County

PSAP → Enloe Dispatch Center → On Scene

Response Time Clock Starts Here → Response Time Clock Ends Here

Enloe Ambulance – Butte County

PSAP → Enloe Dispatch Center → On Scene

Response Time Clock Starts Here → Response Time Clock Ends Here

First Responder Ambulance – Butte County

PSAP → First Responder Dispatch Center → On Scene

Response Time Clock Starts Here → Response Time Clock Ends Here
SUBJECT: 9-1-1 AMBULANCE RESPONSE TIME CRITERIA

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 9-1-1 ambulance response time if previously approved by the Agency and the following criteria are met:

1. Personnel are employed by / working for the 9-1-1 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 9-1-1 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 will include the following information:

- Total response time for the initial ALS overhead personnel.
- Total response time for the transport ambulance.
- 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.
SUBJECT: 9-1-1 AMBULANCE RESPONSE TIME CRITERIA

I. 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.

J. Every ambulance service shall submit to the S-SV EMS Agency data system, via the S-SV scannable PCR or other electronic means, the following information:

   1. Response Time Clock Start Time for all 9-1-1 call or 7 digit access call dispatched code 3.

   2. On scene time.

K. 9-1-1 ambulance providers shall submit a monthly response time compliance report for all code 3 calls, utilizing CAD data, to the S-SV EMS Agency.
## RESPONSE TIME STANDARDS
### NEVADA COUNTY

**SIERRA NEVADA MEMORIAL HOSPITAL AMBULANCE**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grass Valley and Nevada City</td>
<td>9 minutes 90% of the time</td>
</tr>
<tr>
<td>Sierra Nevada Rural 15:</td>
<td></td>
</tr>
<tr>
<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>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td>Sierra Nevada – Rural 20:</td>
<td></td>
</tr>
<tr>
<td>Those portions of Higgins FPD not contained in the 15 min response zone. Peardale-Chicago Park FPD.</td>
<td>20 minutes 90% of the time</td>
</tr>
<tr>
<td>Sierra Nevada – Wilderness</td>
<td>As soon as possible</td>
</tr>
</tbody>
</table>

**PENN VALLEY FIRE PROTECTION DISTRICT**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penn Valley Proper &amp; Lake Wildwood</td>
<td>ALS on scene 10 minutes 90% of the time and ambulance on scene 15 mins 90% of the time</td>
</tr>
<tr>
<td>Penn Valley Rural</td>
<td></td>
</tr>
<tr>
<td>Penn Valley - Wilderness</td>
<td>As soon as possible</td>
</tr>
</tbody>
</table>

**TRUCKEE FIRE PROTECTION DISTRICT**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response Time</th>
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</thead>
<tbody>
<tr>
<td>Truckee</td>
<td>10 minutes 90% of the time</td>
</tr>
<tr>
<td>Truckee Rural 15:</td>
<td></td>
</tr>
<tr>
<td>Tahoe Donner, West-End Donner Lake with South Shore Drive, Prosser Lakeview, Prosser Lake Acreage, Wolfe Estates.</td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td>Truckee Rural 20</td>
<td>20 minutes 90% of the time</td>
</tr>
<tr>
<td>Truckee - Wilderness</td>
<td>As soon as possible</td>
</tr>
</tbody>
</table>

**DONNER SUMMIT FIRE PROTECTION DISTRICT**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donner Summit Fire</td>
<td>20 minutes 90% of the time</td>
</tr>
<tr>
<td>Donner Summit Fire - Wilderness</td>
<td>As soon as possible</td>
</tr>
</tbody>
</table>
# SUBJECT: 9-1-1 RESPONSE TIME CRITERIA – COLUSA COUNTY

<table>
<thead>
<tr>
<th>RESPONSE TIME STANDARDS</th>
<th>COLUSA COUNTY</th>
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</thead>
<tbody>
<tr>
<td>COLUSA AMBULANCE (ENLOE)</td>
<td></td>
</tr>
<tr>
<td>Colusa</td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td>Williams</td>
<td>8 minutes 90% of the time</td>
</tr>
</tbody>
</table>

Effective Date: 12/01/2010  
Date last Reviewed / Revised: 06/10  
Next Review Date: 06/2013  
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SUBJECT: 9-1-1 RESPONSE TIME CRITERIA – BUTTE COUNTY

RESPONSE TIME STANDARDS

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<tr>
<td>Chico 8</td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td>Chico 15</td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td>Gridley 8</td>
<td>8 minutes 90% of the time</td>
</tr>
<tr>
<td>Gridley 15</td>
<td>15 minutes 90% of the time</td>
</tr>
<tr>
<td>Butte County Rural 25</td>
<td>25 minutes 90% of the time</td>
</tr>
<tr>
<td>Butte County Wilderness</td>
<td>As soon as possible</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST RESPONDER AMBULANCE</th>
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</thead>
<tbody>
<tr>
<td>Chico 8</td>
</tr>
<tr>
<td>Chico 15</td>
</tr>
<tr>
<td>Paradise 10</td>
</tr>
<tr>
<td>Paradise 15</td>
</tr>
<tr>
<td>Oroville 8</td>
</tr>
<tr>
<td>Oroville 15</td>
</tr>
<tr>
<td>Butte County Rural 25</td>
</tr>
<tr>
<td>Butte County Wilderness</td>
</tr>
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Effective Date: 12/01/2010
Next Review Date: 10/2013
Approved:

Date last Reviewed / Revised: 10/10
Page 1 of 1
SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY
REFERENCE NO. 441

SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS:
SERVICE PROVIDER REQUIREMENTS & RESPONSIBILITIES

PURPOSE:

To establish the requirements and responsibilities for an S-SV EMS approved ALS ambulance provider’s paramedics to monitor and/or use any of the following during interfacility transports:

A. Magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions
B. Blood transfusions
C. Automatic Transport Ventilators (ATV’s)

AUTHORITY:


California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

Any ALS ambulance providers wishing to utilize paramedics to perform any of the interfacility transport optional skills shall be approved by the S-SV EMS Agency.

Any ALS ambulance provider utilizing paramedics to perform any of the interfacility transport optional skills shall meet all requirements set forth by State law, regulations and S-SV EMS policy.

Only those paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director on interfacility transport optional skills will be permitted to utilize such skills during interfacility transports.

A. PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS
PROGRAM TRAINING REQUIREMENTS.

ALS ambulance service providers utilizing paramedics to perform interfacility transport optional skills shall:
SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS:  
SERVICE PROVIDER REQUIREMENTS & RESPONSIBILITIES  

1. Utilize the appropriate training program(s) approved or provided by the S-SV EMS Agency, including the final written and skills examination.  

2. Provide the following minimum initial training in paramedic interfacility optional skills:  

   a. Monitoring IV blood transfusions – a minimum of two (2) hours.  
   b. Monitoring IV magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions – a minimum of two (2) hours.  
   c. Monitoring Automatic Transport Ventilators (ATV’s) – a minimum of two (2) hours.  

3. Provide all training equipment necessary to ensure a sound paramedic interfacility optional skills training program (i.e. manikins, infusion devices, ATV’s, audiovisual aids, etc.).  

4. Utilize only physicians or RN instructors to teach the required curriculum.  

5. Inform the S-SV EMS Agency of all course dates, times and locations.  

B. RECORDS/DATA COLLECTION:  

1. The paramedic must obtain a copy of the transferring physician's orders and attach them to the PCR.  

2. Patients on blood transfusions will have vital signs monitored and documented every 15 minutes and immediately if there is any change in patient status or change in transfusion rate.  

3. Patients on magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions will have vital signs monitored and documented every 15 minutes.  

4. Patients on ATV’s will have vital signs monitored and documented every 15 minutes and immediately if there is any change in patient status or adjustment of the ATV settings.  

C. CONTINUOUS QUALITY IMPROVEMENT (CQI)  

100% of calls will be audited by the provider agency CQI process. Audits will assess compliance with physician orders and regional protocols, including base hospital contact in emergency situations. Reports will be sent to the S-SV EMS Agency as requested.
D. OTHER PROGRAM REQUIREMENTS

The ALS ambulance provider shall maintain a roster of all paramedic personnel authorized to provide any of the interfacility optional skills.

CROSS REFERENCES:

Prehospital Care Policy Manual

Paramedic Interfacility Transport Optional Skills: Transferring Hospital Requirements, Reference No. 341

Paramedic Interfacility Transport Optional Skills: Application and Approval Process, Reference No. 442

Intravenous Infusion of Magnesium Sulfate, Nitroglycerin, Heparin and/or Amiodarone During Interfacility Transports, Reference No. 841

Automatic Transport Ventilators During Interfacility Transports, Reference No. 842

Continuation of Pre-existing Blood Transfusions During Interfacility Transports, Reference No. 843
This page intentionally left blank
SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS: APPLICATION AND APPROVAL PROCESS.

PURPOSE:

To establish the initial application process and procedure for approval of S-SV EMS ALS ambulance provider’s paramedics to monitor and/or use any of the following during interfacility transports:

A. Blood transfusions
B. Magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions
C. Automatic Transport Ventilators (ATV’s)

AUTHORITY:


California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

An ALS ambulance provider utilizing paramedics to perform any of the interfacility transport optional skills shall meet all requirements set forth by State law, regulations and S-SV EMS policy.

A. PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS PROGRAM: APPLICATION FOR APPROVAL REQUIREMENTS:

1. Any ALS ambulance provider wishing to utilize paramedics to perform any of the interfacility transport optional skills shall submit a “Paramedic Interfacility Transport Optional Skills: Application for Approval” packet to the S-SV EMS Agency.

2. All applicant agencies shall fully complete the application packet. Incomplete applications will not be processed.

The required information / documentation of a complete application shall include the following:

Effective Date: 12/01/2010
Date last Reviewed / Revised: 09/10
Next Review Date: 09/2013
Page 1 of 4

Approved:

SIGNATURE ON FILE
S-SV EMS Medical Director

SIGNATURE ON FILE
S-SV EMS Regional Executive Director
SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS: APPLICATION AND APPROVAL PROCESS.

a. A letter of intent to provide the service (s) of paramedics monitoring pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports. This letter shall be signed by the Chief Operations Officer, and ALS Medical Director and express willingness to abide by all S-SV EMS Agency policies, procedures and program requirements.

b. Call volume of anticipated interfacility transports that will provide the service of paramedics monitoring pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s.

c. Equipment identification. Identification of brand name, model number and all pertinent information for the mechanical infusion pump(s) or ATV that will be utilized by the service provider.

d. A copy of the service providers Continuous Quality Improvement (CQI) program, including name(s) of personnel responsible for the program.

e. Name and CV / resume of the physician or RN proposed as program instructor.

f. Outline or description of the service provider’s plan for provision of the training program.

g. ALS ambulance service provider policies and procedures relevant to paramedics monitoring pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports.

h. Personnel Information:

- Number of proposed paramedic personnel to be trained and authorized to provide monitoring of pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports.

- Number of ALS ambulances staffed with paramedic personnel to be trained and authorized to provide monitoring of pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports.

- Proposed target date for beginning service.
B. S-SV EMS AGENCY PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS PROGRAM APPROVAL PROCESS:

1. The S-SV EMS Agency shall notify the service provider submitting its application to provide the service of paramedics monitoring pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports approval within seven (7) days of receiving the request that:

   a. The application has been received;

   b. The application contains or does not contain the requested information, and;

   c. What information, if any, is missing from the application

2. Program approval or disapproval shall be made, in writing, to the applicant within a reasonable period of time, after receipt of all required documentation. This period shall not exceed forty-five (45) days.

C. PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS PROGRAM IMPLEMENTATION REQUIREMENTS:

Prior to implementation of an S-SV approved Program for paramedics to monitor pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports, the ALS ambulance provider shall complete and submit to the EMS Agency the following:

A list of all paramedics authorized to monitor pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or ATV’s during interfacility transports with the following:

1. Paramedic state license number and expiration date.

2. Proof of completion of initial training program(s) as indicated in S-SV EMS policy # 441 (Paramedic interfacility transport optional skills: Service provider requirements and responsibilities) including successful completion of written and skill examinations.

CROSS REFERENCES:

Prehospital Care Policy Manual

Paramedic Interfacility Transport Optional Skills: Transferring Hospital Requirements, Reference No. 341
REFERENCE NO. 442

SUBJECT: PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS: APPLICATION AND APPROVAL PROCESS.

- Paramedic Interfacility Transport Optional Skills: Service Provider Requirements and Responsibilities, Reference No. 441
- Intravenous Infusion of Magnesium Sulfate, Nitroglycerin, Heparin &/or Amiodarone During Interfacility Transports, Reference No. 841
- Automatic Transport Ventilators During Interfacility Transports, Reference No. 842
- Continuation of Pre-existing Blood Transfusions During Interfacility Transports, Reference No. 843
SIERRA-SACRAMENTO VALLEY EMS AGENCY
PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS
SERVICE PROVIDER APPLICATION

<table>
<thead>
<tr>
<th>SERVICE PROVIDER:</th>
<th>CHIEF OPERATIONS OFFICER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON:</td>
<td>MEDICAL DIRECTOR:</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>CITY:</td>
<td>ZIP CODE:</td>
</tr>
<tr>
<td>PHONE #:</td>
<td>FAX #:</td>
</tr>
<tr>
<td>E-MAIL ADDRESS:</td>
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</tbody>
</table>

Attach the following:

**DESCRIPTION**
(For detailed description, see S-SV Policy Reference No. 442.)

<table>
<thead>
<tr>
<th>ENCLOSED</th>
<th>APPROVED (S-SV use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>Letter of Intent, signed by Chief Operations Officer, to provide paramedic monitoring of pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or Automatic Transport Ventilators (ATV’s) during interfacility transports.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>Call Volume of anticipated interfacility transports.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
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<tr>
<td>Equipment Identification. Mechanical infusion pump and/or Automatic Transport Ventilator information.</td>
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<td>d.</td>
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<td>CQI program.</td>
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<td>e.</td>
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<tr>
<td>Program instructor. Name and CV/resume of the physician or RN instructor.</td>
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<td>f.</td>
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<tr>
<td>Training Program.</td>
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<td>g.</td>
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<tr>
<td>Policies &amp; Procedures.</td>
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<tr>
<td>h.</td>
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<tr>
<td>Personnel Information:</td>
<td></td>
</tr>
<tr>
<td>- # of proposed paramedic personnel to be trained &amp; authorized.</td>
<td></td>
</tr>
<tr>
<td>- # of ALS staffed ambulances staffed with paramedic personnel to be trained and authorized.</td>
<td></td>
</tr>
<tr>
<td>- Proposed target date for beginning service.</td>
<td></td>
</tr>
</tbody>
</table>

__________________________         __________
Chief Operations Officer                       Date
Medical Director                               Date

Submit this application, with appropriate supporting documentation, to:

QI/Education Coordinator
S-SV EMS Agency
5995 Pacific Street
Rocklin, CA 95677

Phone (916) 625-1714
Fax # (916) 625-1730

S-SV EMS AGENCY USE ONLY

<table>
<thead>
<tr>
<th>Date rec’d</th>
<th>Reviewed by</th>
<th>Date Approved</th>
<th>Letter sent</th>
<th>Personnel list</th>
<th>Orientation Completed</th>
<th>Provider #</th>
</tr>
</thead>
</table>

Updated 09/2010
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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.

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.

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.
SUBJECT: TACTICAL MEDICINE OPERATIONAL PROGRAMS

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 of personnel utilized for the particular tactical medicine program (TEMS BLS or TEMS ALS).
<table>
<thead>
<tr>
<th>REFERENCE NO. 500</th>
<th>SUBJECT: INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>505</td>
<td>Patient Destination</td>
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<tr>
<td>505-A</td>
<td>Hospital Capabilities Reference</td>
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<tr>
<td>506</td>
<td>Cardiovascular “STEMI” Receiving Centers</td>
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<tr>
<td>507</td>
<td>Stroke System Triage &amp; Patient Destination</td>
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<tr>
<td>510</td>
<td>Emergency Department Downgrade and/or Cessation</td>
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<tr>
<th>Hospital Name</th>
<th>County</th>
<th>Base</th>
<th>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>
<th>Burn Receiving Center</th>
<th>STEMI Receiving Center</th>
<th>Stroke Receiving Center</th>
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<tr>
<td>Biggs Gridley Memorial Hospital</td>
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<td>Base</td>
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<tr>
<td>Feather River Hospital</td>
<td>Butte</td>
<td>Base</td>
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<tr>
<td>Oroville Hospital</td>
<td>Butte</td>
<td>Base</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Colusa Regional Medical Center</td>
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<tr>
<td>Sierra Nevada Memorial Hospital</td>
<td>Nevada</td>
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<tr>
<td>Kaiser Roseville Medical Center</td>
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<td>Modified Base</td>
<td>X</td>
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<tr>
<td>Sutter Auburn Faith Hospital</td>
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<td>X</td>
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<td>Base</td>
<td>X</td>
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<tr>
<td>Tahoe Forest Hospital</td>
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<td>X</td>
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<tr>
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<tr>
<td>Mercy General Hospital</td>
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<tr>
<td>Mercy Hospital Folsom</td>
<td>Sacramento</td>
<td>Receiving</td>
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<tr>
<td>Mercy San Juan Medical Center</td>
<td>Sacramento</td>
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<td>Methodist Hospital</td>
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<td>Receiving</td>
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<td>UC Davis Medical Center</td>
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<tr>
<td>Fairchild Medical Center</td>
<td>Siskiyou</td>
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<tr>
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<td>Siskiyou</td>
<td>Base</td>
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<tr>
<td>Mayers Memorial Hospital</td>
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<td>Base</td>
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<td>Mercy Medical Center Redding</td>
<td>Shasta</td>
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<tr>
<td>Shasta Regional Medical Center</td>
<td>Shasta</td>
<td>Base</td>
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</tbody>
</table>
## SSV EMS MCI CONTROL FACILITIES

<table>
<thead>
<tr>
<th>Control Facility</th>
<th>County / Area of Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enloe Medical Center</td>
<td>Butte and Colusa Counties</td>
</tr>
<tr>
<td>Rideout Memorial Hospital</td>
<td>Sutter and Yuba Counties</td>
</tr>
<tr>
<td>Sierra Nevada Memorial Hospital</td>
<td>Western Slope of Nevada County</td>
</tr>
<tr>
<td>Sutter Roseville Medical Center</td>
<td>Western Slope of Placer County</td>
</tr>
<tr>
<td>Tahoe Forest Hospital</td>
<td>Tahoe Basin and Eastern Slope of Nevada and Placer Counties</td>
</tr>
<tr>
<td>Woodland Memorial Hospital</td>
<td>Yolo County</td>
</tr>
<tr>
<td>UC Davis Medical Center</td>
<td>When requested by Woodland Memorial Hospital and agreed to by UCDMC, to handle patient dispersal for those MCI events that occur in Yolo County but patient dispersal will be primarily into Sacramento County</td>
</tr>
<tr>
<td>In progress</td>
<td>Shasta County / Siskiyou County / Tehama County</td>
</tr>
</tbody>
</table>
SUBJECT: STROKE SYSTEM TRIAGE AND PATIENT DESTINATION

PURPOSE:

The purpose of this policy is to describe the Sierra Sacramento Valley EMS (S-SV EMS) stroke system. This system is designed to provide timely, appropriate care to patients who have suffered symptoms of a stroke within 2.5 hours of onset of symptoms. Acute Stroke Patients will be transported to a Stroke Receiving Center in accordance with S-SV EMS policy.

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(c), Title 22, Division 9, Chapter 4, § 100169

DEFINITIONS:

A. Acute Stroke Patient – A patient who meets assessment criteria for an acute stroke in accordance with S-SV EMS patient care protocols and whose onset of symptoms is 2.5 hours or less.

B. Stroke Receiving Center – An acute care hospital that has successfully completed and maintains Joint Commission Accreditation as a Primary Stroke Center or that has been alternately approved by the S-SV EMS Agency, and enters into a memorandum of understanding (MOU) with S-SV EMS relative to being a Stroke Receiving Center.

POLICY:

A. Identification and Destination of the Acute Stroke Patient:

1. Criteria for the assessment, identification and treatment of an acute stroke patient will be based on S-SV EMS treatment protocols.

2. Patients identified by prehospital personnel as having the onset of stroke symptoms within the past 2.5 hours will be transported to a Stroke Receiving Center if transport time is less than 30 minutes.
3. If there is any question as to the status of a patient within the 30 minute catchment area of a Stroke Receiving Center with symptoms of a stroke, prehospital personnel will consult with the ED physician at the closest Stroke Receiving Center as early as possible in the patient’s evaluation.

4. If the onset of symptoms is unknown or exceeds 2.5 hours, the patient should be transported per S-SV EMS routine destination criteria.

5. If the patient has an uncontrolled airway or is in cardiac arrest the patient should be transported to the closest receiving facility.

B. Notification of the Stroke Receiving Center:

As soon as feasible, preferably from the scene, prehospital personnel will contact the intended Stroke Receiving Center and inform them that a stroke patient is enroute to that facility. It is recommended that the report be started with the statement that this is a “Stroke Alert”. The prehospital report will include at a minimum:

1. The nature of the symptoms
2. The time of onset of symptoms or when patient was last seen normal
3. The blood glucose
4. Vital signs
5. Treatment provided

C. Diversion by a Stroke Receiving Center:

Stroke Receiving Centers will not close to acute stroke patients except in the following circumstances:

1. A declared internal disaster
2. There is a failure of all CT scanners

D. Documentation:

A complete Patient Care Report (PCR) shall be left at the Stroke Receiving Center for all stroke patients before prehospital personnel leave the receiving hospital.

E. Notification:

S-SV EMS shall be notified as soon as possible if any of the following occur:
SUBJECT: STROKE SYSTEM TRIAGE AND PATIENT DESTINATION

1. A patient within the 30 minute catchment area of a Stroke Receiving Center transported by the EMS system is identified as an acute stroke patient by the receiving facility and was not transported to a Stroke Receiving Center.

2. Any instance of diversion of a stroke patient by a Stroke Receiving Center.

3. An EMS field provider fails to leave a completed PCR at the receiving facility at the time of initial patient transport.

F. Transferring an Acute Stroke Patient to a higher level of stroke care:

In the event that an acute stroke patient needs to be transferred to a higher level of stroke care the emergency department will:

1. Follow their facility’s policies and procedures regarding patient transfers.

2. Request an ALS ambulance utilizing the 9-1-1 system to transport the patient to a Stroke Receiving Center, unless there is an equivalent agreement for emergent transport in place with another S-SV approved provider. If patient care has been initiated that exceeds the prehospital provider’s scope of practice, qualified medical or nursing staff will accompany the patient in the ambulance, or a Critical Care Transport unit may be utilized if their response time is appropriate.

3. Provide the ambulance personnel with a complete patient report and all appropriate documentation including a CT scan. Do not delay transport of the patient if complete documentation is not available. If complete documentation is not sent with the ambulance, the sending hospital will Fax the report to the Stroke Receiving Center in sufficient time that it should arrive prior to the patient.

CROSS REFERENCES:

Prehospital Care Policy Manual

Patient Destination, Reference No. 505

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

Suspected CVA / Stroke, Reference No. N-3
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SUBJECT: ALS INVENTORY

PURPOSE:

To establish a standardized inventory on all S-SV approved Advanced Life Support 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, Section 100173

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 approved ALS 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
<table>
<thead>
<tr>
<th>Equipment Type</th>
<th>ALS Transport</th>
<th>ALS NON Transport</th>
<th>BIKES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RADIO EQUIPMENT</strong></td>
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<td></td>
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</tr>
<tr>
<td>Mobile UHF Med-Net Radio</td>
<td>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>
</tr>
<tr>
<td><strong>MISCELLANEOUS EQUIPMENT &amp; SUPPLIES</strong></td>
<td></td>
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<tr>
<td>Map Book (covering the areas the ambulance provides service)</td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
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<tr>
<td>D.O.T Emergency Response Guidebook</td>
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<tr>
<td>FIRESCOPE Field Operations Guide (FOG)</td>
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<tr>
<td>Hazardous Materials medical management reference</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>EMS response forms &amp; AMA forms</td>
<td>10 each</td>
<td>5 each</td>
<td>5 each</td>
</tr>
<tr>
<td>Triage Tags</td>
<td>10 each</td>
<td>10 each</td>
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<tr>
<td>Infection control packs (per crew member)</td>
<td>1 pk each</td>
<td>1 pk each</td>
<td>1 pk</td>
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<tr>
<td>Antiseptic hand wipes or waterless hand sanitizer</td>
<td>10 / 1</td>
<td>10 / 1</td>
<td>10 / 1</td>
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<tr>
<td>Covered waste container (red bio hazard bags acceptable)</td>
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<td>Adult &amp; Pediatric BP cuff</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
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<tr>
<td>Thigh BP cuff</td>
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<tr>
<td>Stethoscope</td>
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<tr>
<td>Flashlight or Penlight</td>
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<td>Bedpan or Fracture pan</td>
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<td>Urinal</td>
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<td>Sharps container</td>
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<td>Padded soft wrist &amp; ankle restraints</td>
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<td>Pillows, sheets, pillow cases, towels</td>
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<td>Blankets</td>
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<td>Emesis basin / disposable emesis bags</td>
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<td>Length based Pediatric Resuscitation Tape (Broselow)</td>
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<td>1</td>
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<tr>
<td>Ambulance cot with straps to secure patient to cot and necessary equipment to properly secure cot in vehicle</td>
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<tr>
<td>Collapsible stretcher (Breakaway Flat) with straps to secure patient</td>
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<tr>
<td>Thermometer (optional)</td>
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<tr>
<td><strong>BIOMEDICAL EQUIPMENT &amp; SUPPLIES</strong></td>
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<tr>
<td>Monitor / Defibrillator Equipment &amp; Supplies</td>
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</tr>
<tr>
<td>Portable Monitor/Defibrillator - Battery operated, with ECG printout, capable of synchronized cardioversion. (Transcutaneous Pacing, Waveform Capnography, &amp;/or 12 Lead capability optional).</td>
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<td>1</td>
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<tr>
<td>AED with cardiac monitoring and manual defibrillation capabilities (optional in place of portable monitor / defibrillator above for bike teams only)</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Spare monitor/defibrillator battery</td>
<td>1</td>
<td>1</td>
<td>as needed</td>
</tr>
<tr>
<td>Defibrillator paddles - adult &amp; pediatric with defibrillation gel pads or paddle conduction gel OR Hands free defibrillator patches - adult &amp; pediatric</td>
<td>1 set each</td>
<td>1 set each</td>
<td>1 set each</td>
</tr>
<tr>
<td>Electrode leads (wires)</td>
<td>2 sets</td>
<td>2 sets</td>
<td>1 set</td>
</tr>
<tr>
<td>ECG paper</td>
<td>2 rolls</td>
<td>2 rolls</td>
<td>as needed</td>
</tr>
<tr>
<td>Adult disposable ECG electrodes</td>
<td>4 sets</td>
<td>2 sets</td>
<td>2 sets</td>
</tr>
<tr>
<td>Pediatric disposable ECG electrodes</td>
<td>2 sets</td>
<td>1 set</td>
<td>2 sets</td>
</tr>
<tr>
<td><strong>Miscellaneous Biomedical Equipment &amp; Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse Oximeter</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Capnometer (optional)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Co-Oximeter (optional)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Glucometer</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Glucometer test strips</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Lancets</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td><strong>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen Delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“H” or “M” oxygen tank mounted in ambulance</td>
<td>1</td>
<td>0</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>
</tr>
<tr>
<td>Equipment Description</td>
<td>ALS Transport</td>
<td>ALS NON Transport</td>
<td>BIKE</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------</td>
<td>------------------</td>
<td>-----</td>
</tr>
<tr>
<td><strong>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES (cont.)</strong></td>
<td></td>
<td></td>
<td></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>1</td>
</tr>
<tr>
<td>Portable oxygen regulator with liter flow</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult non-rebreather oxygen mask</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric oxygen mask</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Nasal cannula</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hand held nebulizer</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Aerosol / nebulizer mask</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Bag-Valve Device (with 02 inlet, reservoir &amp; one way valve)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult (1000 cc bag vol.)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric (450 - 500 cc bag vol.)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Bag-Valve Mask (transparent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large (adult)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medium (adult)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Small (adult)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neonatal</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>BLS Airways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal Airways (sizes 0-6 or equivalent sizes)</td>
<td>2 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>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td><strong>Suction Equipment &amp; Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction catheters - 6 fr, 8 fr, 10 fr, 14 fr</td>
<td>2 each</td>
<td>2 each</td>
<td>0</td>
</tr>
<tr>
<td>Tonsilar tip suction handle</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Portable mechanical suction unit (manual suction device including adult &amp; pediatric suction tubes acceptable for bike teams)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Advanced Airway Equipment &amp; Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laryngoscope handle</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Batteries - extra set</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bulb - extra bulb for adult and pediatric blade</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Miller (straight blade) sizes 0-4</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Macintosh (curved blade) sizes 3-4</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Magill forceps - adult &amp; pediatric</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Water soluble lubricant (K-Y jelly or equivalent)</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Topical vasoconstrictor (Neosynephrine or equivalent)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2% Lidocaine jelly</td>
<td>1 tube</td>
<td>1 tube</td>
<td>1 tube</td>
</tr>
<tr>
<td>Uncuffed endotracheal tubes, sizes 2.5, 3.0</td>
<td>2 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<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>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Cuffed endotracheal tube, size 9.0</td>
<td>2 each</td>
<td>2 each</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>
</tr>
<tr>
<td>Flex Guide ETT introducer - caude tip 15 fr x 70 cm</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>ET tube holder</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Esophageal Tracheal Airway Device - Adult 37 and 41 Fr <strong>OR</strong></td>
<td>1 each</td>
<td>1 each</td>
<td>0</td>
</tr>
<tr>
<td>King Airway Device - Size 3, Size 4, Size 5</td>
<td>2 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>End tidal CO2 detector device - disposable single patient use colorimetric device (adult &amp; pediatric) or disposable capnography circuit</td>
<td>2 each</td>
<td>2 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Esophageal Intubation Detector Device (EDD) (optional for providers using waveform capnography)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Meconium aspirator</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Airway airflow monitor (optional)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Inspiratory Impedance Threshold Device (optional)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>S-SV approved CPAP equipment</td>
<td>as approved</td>
<td>as approved</td>
<td>0</td>
</tr>
<tr>
<td>Jet insufflation device <strong>OR</strong> ENK Flow Modulator</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Updated 12/01/2010
## Sierra-Sacramento Valley EMS Agency
### EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS

<table>
<thead>
<tr>
<th></th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALS Transport</td>
</tr>
</tbody>
</table>

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

- **Needle thoracostomy kit with minimum 14 ga X 3” catheter specifically designed for needle decompression**: 1

### IMMOBILIZATION EQUIPMENT & SUPPLIES

- **Ked**: 1
- **Long spine board with straps**: 2
- **Pediatric spine board**: 1
- **Foam-filled or equivalent S-SV approved head immobilization device**: 2 pair
- **Traction splint: Hare, Sager or equivalent**: 1
- **Arm & leg splints (i.e. cardboard, SAM type, vacuum)**: 3 each
- **Tape (optional) *Type approved by SSV EMSA Medical Director**: 1 roll
- **Cervical Collars (rigid) - large, medium, small, pediatric OR adjustable adult & pediatric**: 2 each

### OBSTETRICAL EQUIPMENT & SUPPLIES

- **OB Kit containing a minimum: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe and clean plastic bags** : 2 kits
- **Stocking head cap (infant)**: 2

### BANDAGING EQUIPMENT & SUPPLIES

- **Triangle bandages**: 4
- **Adhesive tape rolls 1” & 2” rolls**: 2 each
- **Sterile 4x4 compresses**: 12
- **Non sterile 4x4 compresses**: 50
- **Kling/Kerlix in 2”, 3” or 4” rolls**: 10
- **Trauma dressing (10”x30” or larger universal dressings)**: 4
- **Surgipads (optional)**: 6
- **Band-Aids**: 1 box each
- **Sterile petroleum impregnated dressing**: 4
- **Asherman Chest Seal (optional)**: 1
- **Cold packs and heat packs**: 2 each
- **Gloves (unsterile) various sizes**: 1 box each
- **Sterile saline for irrigation**: 2 liters
- **Potable water**: 2 liters
- **Bandage shears**: 1 pr
- **S-SV EMS Agency approved commercial tourniquet device (optional)**: 1

### IV / MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES

- **Catheter over needle- 14ga, 16ga, 18ga, 20 ga**: 6 each
- **Catheter over needle- 22ga, 24ga**: 2 each
- **Micro-drip & Macro-drip venosets OR Selectable drip tubing**: 4 each
- **Blood administration tubing (optional)**: 2
- **IV extension**: 4
- **IV start pack or equivalent with tourniquets**: 4
- **Alcohol wipes & Betadine swabs**: 20 each
- **Chlorhexidine swabs/skin prep**: 5 each

### Syringes / Needles / Medication Administration Devices

- **TB / 1 cc syringe**: 3
- **3 - 5 cc syringe**: 3
- **10 - 12 cc syringe**: 3
- **20 cc syringe**: 1
- **50 - 60 cc syringe**: 1
- **22ga, 25 ga safety injection needles**: 2 each
- **Vial access Cannulas**: 2 each
- **Mucosal Atomization Device (MAD)**: 4
- **Arm boards - (short, long)**: 2 each

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*Updated 12/01/2010*
Sierra-Sacramento Valley EMS Agency
EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS

### IV / MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES (cont.)

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Tubes (optional)</td>
<td>ALS Transport: 4, ALS NON Transport: 2, BIKES: 0</td>
</tr>
<tr>
<td>Vacutainer holder (optional)</td>
<td>ALS Transport: 1, ALS NON Transport: 0, BIKES: 0</td>
</tr>
<tr>
<td>Vacutainer needles (optional)</td>
<td>ALS Transport: 4, ALS NON Transport: 4, BIKES: 0</td>
</tr>
<tr>
<td>Vials or pre-filled syringes - Sterile Normal Saline for injection (optional)</td>
<td>ALS Transport: 2, ALS NON Transport: 2, BIKES: 1</td>
</tr>
</tbody>
</table>

### Intraosseous Access Equipment & Supplies

**Needles (Baxter Jamshidi/Illinois) for manual pediatric access**
- 15 ga x 3/8" & 15 ga x 1 7/8" OR 15 ga x 3/8" - 1 7/8" adjustable needles
  - ALS Transport: 2 each, ALS NON Transport: 1 each, BIKES: 1 each

**OR**

- **FDA Approved drill type device** for adult and pediatric lower extremity I/O access, approved by the provider Medical Director or LEMSA Medical Director
  - ALS Transport: 1, ALS NON Transport: 1, BIKES: 1
- Pediatric I/O needles for drill type device 15 ga x 15mm long
  - ALS Transport: 2, ALS NON Transport: 1, BIKES: 1
- Adult I/O needles for drill type device 15 ga x 25mm long
  - ALS Transport: 2, ALS NON Transport: 1, BIKES: 1
- Lidocaine HC1 2% (100mg/5ml) in I/O kit
  - ALS Transport: 1, ALS NON Transport: 1, BIKES: 1

### IV SOLUTIONS

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal saline - 1000 cc bag</td>
<td>ALS Transport: 8, ALS NON Transport: 3, BIKES: 2</td>
</tr>
<tr>
<td>Normal saline - 250 cc bag</td>
<td>ALS Transport: 2, ALS NON Transport: 1, BIKES: 0</td>
</tr>
</tbody>
</table>

### MEDICATIONS

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activated charcoal (50 gm)</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 0</td>
</tr>
<tr>
<td>Adenosine 6 mg - vial or pre-filled syringe</td>
<td>ALS Transport: 5, ALS NON Transport: 5, BIKES: 5</td>
</tr>
<tr>
<td>Albuterol - 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5cc, without preservatives, is required for dilution of each dose.</td>
<td>ALS Transport: 3, ALS NON Transport: 2, BIKES: 2</td>
</tr>
<tr>
<td>Amiodarone 3 ml - 150 mg (50 mg/ml)</td>
<td>ALS Transport: 6, ALS NON Transport: 6, BIKES: 6</td>
</tr>
<tr>
<td>Aspirin (chewable)</td>
<td>ALS Transport: 1 bottle, ALS NON Transport: 1 bottle, BIKES: 1 bottle</td>
</tr>
<tr>
<td>Atropine (1.0 mg/10ml)</td>
<td>ALS Transport: 6, ALS NON Transport: 6, BIKES: 4</td>
</tr>
<tr>
<td>Atropine 10mg multidose vials (optional)</td>
<td>ALS Transport: (Optional), ALS NON Transport: (Optional), BIKES: (Optional)</td>
</tr>
<tr>
<td>Benadryl (50 mg/ml)</td>
<td>ALS Transport: 2, ALS NON Transport: 2, BIKES: 2</td>
</tr>
<tr>
<td>Benadryl elixir - 100 mg</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 1</td>
</tr>
<tr>
<td>Calcium chloride 10% - (1 gm/10ml)</td>
<td>ALS Transport: 4, ALS NON Transport: 2, BIKES: 1</td>
</tr>
<tr>
<td>Dextrose 50% (25gm/50ml)</td>
<td>ALS Transport: 2, ALS NON Transport: 2, BIKES: 1</td>
</tr>
<tr>
<td>Dextrose 25% (12.5gm/10ml)</td>
<td>ALS Transport: 2, ALS NON Transport: 1, BIKES: 0</td>
</tr>
<tr>
<td>Dopamine 400 mg</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 0</td>
</tr>
<tr>
<td>Epinephrine 1:1,000</td>
<td>ALS Transport: 4 mg, ALS NON Transport: 2 mg, BIKES: 2 mg</td>
</tr>
<tr>
<td>Epinephrine 1:10,000 (1mg/10ml)</td>
<td>ALS Transport: 8, ALS NON Transport: 4, BIKES: 4</td>
</tr>
<tr>
<td>Furosemide 40 mg (10mg/ml)</td>
<td>ALS Transport: 2, ALS NON Transport: 2, BIKES: 2</td>
</tr>
<tr>
<td>Glucagon 1mg (1unit)</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 1</td>
</tr>
<tr>
<td>Glucose paste OR Glucose solution (oral prepackaged)</td>
<td>ALS Transport: 2, ALS NON Transport: 2, BIKES: 1</td>
</tr>
<tr>
<td>Mark-I / Duo Dote Nerve Agent Antidote Kits (optional)</td>
<td>ALS Transport: (Optional), ALS NON Transport: (Optional), BIKES: (Optional)</td>
</tr>
<tr>
<td>Naloxone (Narcan) 2.0 mg</td>
<td>ALS Transport: 4, ALS NON Transport: 4, BIKES: 2</td>
</tr>
<tr>
<td>Nitroglycerin 0.4 mg/tab (1/150) bottle OR Nitroglycerine spray actuation</td>
<td>ALS Transport: 2, ALS NON Transport: 1, BIKES: 1</td>
</tr>
<tr>
<td>Praisodixime Chloride (2-PAM) 1 gm / 20 ml vial (optional)</td>
<td>ALS Transport: (Optional), ALS NON Transport: (Optional), BIKES: (Optional)</td>
</tr>
<tr>
<td>Sodium Bicarbonate (50mEq/50ml)</td>
<td>ALS Transport: 2, ALS NON Transport: 1, BIKES: 1</td>
</tr>
<tr>
<td>Zofran (4mg/2ml vial)</td>
<td>ALS Transport: 4, ALS NON Transport: 2, BIKES: 2</td>
</tr>
<tr>
<td>Zofran Oral Disintegrating Tablets (ODT) 4 mg</td>
<td>ALS Transport: 4, ALS NON Transport: 2, BIKES: 2</td>
</tr>
</tbody>
</table>

### Controlled Substances

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam (Versed) 5 mg/cc concentration</td>
<td>ALS Transport: 20 - 60 mg, ALS NON Transport: 20 - 60 mg, BIKES: 20 mg (Optional)</td>
</tr>
<tr>
<td>Morphine HCL 10 mg/ml unit dose</td>
<td>ALS Transport: 20 - 60 mg, ALS NON Transport: 20 - 60 mg, BIKES: 20 mg (Optional)</td>
</tr>
<tr>
<td>Double lock container system for controlled meds.</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 1</td>
</tr>
<tr>
<td>Controlled substance log sheet</td>
<td>ALS Transport: 1, ALS NON Transport: 1, BIKES: 1</td>
</tr>
</tbody>
</table>

Updated 12/01/2010
SUBJECT: LIMITED ADVANCED LIFE SUPPORT (LALS) INVENTORY

PURPOSE:

To establish a standardized inventory on all S-SV approved Limited Advanced Life Support (LALS) 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, Chapter 3
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 approved LALS 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 - LALS**

#### RADIO EQUIPMENT

<table>
<thead>
<tr>
<th>Item Description</th>
<th>LALS TRANSPORT</th>
<th>LALS NON TRANSPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile UHF Med-Net Radio</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Portable UHF Med-Net Radio OR Portable Cell Phone</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

#### MISCELLANEOUS EQUIPMENT & SUPPLIES

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Map Book (covering the areas the ambulance provides service)</td>
<td>1 each / 1 each</td>
</tr>
<tr>
<td>D.O.T Emergency Response Guidebook</td>
<td>1</td>
</tr>
<tr>
<td>FIRESCOPE Field Operations Guide (FOG)</td>
<td>1</td>
</tr>
<tr>
<td>Hazardous Materials medical management reference</td>
<td>1</td>
</tr>
<tr>
<td>PCR's (written or electronic) &amp; AMA forms</td>
<td>10 each / 5 each</td>
</tr>
<tr>
<td>Triage Tags</td>
<td>10 each / 10 each</td>
</tr>
<tr>
<td>Infection control packs (per crew member)</td>
<td>1 pk each / 1 pk each</td>
</tr>
<tr>
<td>Antiseptic hand wipes or waterless hand sanitizer</td>
<td>10 / 1</td>
</tr>
<tr>
<td>Covered waste container (red bio hazard bags acceptable)</td>
<td>1</td>
</tr>
<tr>
<td>Adult &amp; Pediatric BP cuff</td>
<td>1 each / 1 each</td>
</tr>
<tr>
<td>Thigh BP cuff</td>
<td>1</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>1</td>
</tr>
<tr>
<td>Flashlight or Penlight</td>
<td>1</td>
</tr>
<tr>
<td>Bedpan or Fracture pan</td>
<td>1</td>
</tr>
<tr>
<td>Urinal</td>
<td>1</td>
</tr>
<tr>
<td>Sharps container</td>
<td>1</td>
</tr>
<tr>
<td>Padded soft wrist &amp; ankle restraints</td>
<td>1 set / 1 set</td>
</tr>
<tr>
<td>Pillows, sheets, pillow cases, towels</td>
<td>2 each / 0</td>
</tr>
<tr>
<td>Blankets</td>
<td>2</td>
</tr>
<tr>
<td>Emesis basin / disposable emesis bags</td>
<td>2</td>
</tr>
<tr>
<td>Length based Pediatric Resuscitation Tape (Broselow)</td>
<td>1</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>
</tr>
<tr>
<td>Collapsible stretcher (Breakaway Flat) with straps to secure patient</td>
<td>1</td>
</tr>
<tr>
<td>Thermometer (optional)</td>
<td>1</td>
</tr>
</tbody>
</table>

#### BIOMEDICAL EQUIPMENT & SUPPLIES

**Monitor / Defibrillator Equipment & Supplies**

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portable Monitor/Defibrillator - Battery operated, with ECG printout, capable of synchronized cardioversion.</td>
<td>1</td>
</tr>
<tr>
<td>Spare monitor/ defibrillator battery</td>
<td>1</td>
</tr>
<tr>
<td>Defibrillator paddles - adult &amp; pediatric with defibrillation gel pads or paddle conduction gel OR Hands free defibrillator patches - adult &amp; pediatric</td>
<td>1 set each / 1 set each</td>
</tr>
<tr>
<td>Electrode leads (wires)</td>
<td>2 sets / 2 sets</td>
</tr>
<tr>
<td>ECG paper</td>
<td>2 rolls / 2 rolls</td>
</tr>
<tr>
<td>Adult disposable ECG electrodes</td>
<td>4 sets / 2 sets</td>
</tr>
<tr>
<td>Pediatric disposable ECG electrodes</td>
<td>2 sets / 1 set</td>
</tr>
</tbody>
</table>

**Miscellaneous Biomedical Equipment & Supplies**

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse Oximeter</td>
<td>1</td>
</tr>
<tr>
<td>Glucometer</td>
<td>1</td>
</tr>
<tr>
<td>Glucometer test strips</td>
<td>10</td>
</tr>
<tr>
<td>Lancets</td>
<td>10</td>
</tr>
</tbody>
</table>

**AIRWAY / OXYGEN EQUIPMENT & SUPPLIES**

<table>
<thead>
<tr>
<th>Item Description</th>
<th>MINIMUM QUANTITY REQUIRED</th>
</tr>
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<tbody>
<tr>
<td>&quot;H&quot; or &quot;M&quot; oxygen tank mounted in ambulance</td>
<td>1</td>
</tr>
<tr>
<td>Wall mounted oxygen regulator with liter flow mounted in ambulance</td>
<td>1</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>
</tr>
<tr>
<td>Portable oxygen regulator with liter flow</td>
<td>1</td>
</tr>
<tr>
<td>Adult non-rebreather oxygen mask</td>
<td>6</td>
</tr>
<tr>
<td>Pediatric oxygen mask</td>
<td>2</td>
</tr>
<tr>
<td>Nasal cannula</td>
<td>6</td>
</tr>
</tbody>
</table>

*Updated 12/01/2010*
Sierra-Sacramento Valley EMS Agency
EQUIPMENT AND SUPPLY SPECIFICATIONS - LALS

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<th>LALS NON TRANSPORT</th>
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<tbody>
<tr>
<td>Hand held nebulizer</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Aerosol / nebulizer mask</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bag-Valve Device (with 02 inlet, reservoir &amp; one way valve)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult (1000 cc bag vol.)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric (450 - 500 cc bag vol.)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bag-Valve Mask (transparent)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Large (adult)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medium (adult)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Small (adult)</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neonatal</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>BLS Airways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal Airways (sizes 0-6 or equivalent sizes)</td>
<td>2 each</td>
<td>2 each</td>
<td></td>
</tr>
<tr>
<td>Nasopharyngeal Airways (sizes 24-34 Fr or equivalent sizes)</td>
<td>2 each</td>
<td>2 each</td>
<td></td>
</tr>
<tr>
<td>Water soluble lubricant (K-Y jelly or equivalent)</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Suction Equipment &amp; Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction catheters - 6 fr, 8 fr, 10 fr, 14 fr</td>
<td>2 each</td>
<td>2 each</td>
<td></td>
</tr>
<tr>
<td>Tonsilar tip suction handle</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Portable mechanical suction unit (manual suction device including adult &amp; pediatric suction tubes acceptable for bike teams)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Advanced Airway Equipment &amp; Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Airway tube holder</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Esophageal Tracheal Airway Device - Adult 37 and 41 Fr OR</td>
<td>1 each</td>
<td>1 each</td>
<td></td>
</tr>
<tr>
<td>King Airway Device - Size 3, Size 4, Size 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End tidal CO2 detector device - disposable single patient use colorimetric device (adult) or disposable capnography circuit</td>
<td>2 each</td>
<td>2 each</td>
<td></td>
</tr>
<tr>
<td>Esophageal Intubation Detector Device (EDD)</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>IMMOBILIZATION EQUIPMENT &amp; SUPPLIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ked</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Long spine board with straps</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric spine board</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Foam-filled or equivalent S-SV approved head immobilization device</td>
<td>2 pair</td>
<td>2 pair</td>
<td></td>
</tr>
<tr>
<td>Traction splint: Hare, Sager or equivalent</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Arm &amp; leg splints (i.e. cardboard, SAM type, vacuum)</td>
<td>3 each</td>
<td>3 each</td>
<td></td>
</tr>
<tr>
<td>Tape (optional) *Type approved by SSV EMSA Medical Director</td>
<td>1 roll</td>
<td>1 roll</td>
<td></td>
</tr>
<tr>
<td>Cervical Collars (rigid) - large, medium, small, pediatric OR adjustable adult &amp; pediatric</td>
<td>2 each</td>
<td>2 each</td>
<td></td>
</tr>
<tr>
<td><strong>OBSTETRICAL EQUIPMENT &amp; SUPPLIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB Kit containing: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe, clean plastic bags and stocking head cap.</td>
<td>2 kits</td>
<td>1 kit</td>
<td></td>
</tr>
<tr>
<td><strong>BANDAGING EQUIPMENT &amp; SUPPLIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triangle bandages</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Adhesive tape rolls 1&quot; &amp; 2&quot; rolls</td>
<td></td>
<td>2 each</td>
<td>2 each</td>
</tr>
<tr>
<td>Sterile 4x4 compresses</td>
<td></td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Non sterile 4x4 compresses</td>
<td></td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Kling/Kerlix in 2&quot;, 3&quot; or 4&quot; rolls</td>
<td></td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Trauma dressing (10&quot;x30&quot; or larger universal dressings)</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Surgipads (optional)</td>
<td></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Band-Aids</td>
<td></td>
<td>1 box</td>
<td>1 box</td>
</tr>
<tr>
<td>Sterile petroleum impregnated dressing</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Asherman Chest Seal (optional)</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cold packs and heat packs</td>
<td></td>
<td>2 each</td>
<td>2 each</td>
</tr>
<tr>
<td>Gloves (unsterile) various sizes</td>
<td></td>
<td>1 box each</td>
<td>10 each</td>
</tr>
</tbody>
</table>

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### Sierra-Sacramento Valley EMS Agency

#### EQUIPMENT AND SUPPLY SPECIFICATIONS - LALS

<table>
<thead>
<tr>
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<th><strong>LALS TRANSPORT</strong></th>
<th><strong>LALS NON TRANSPORT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BANDAGING EQUIPMENT &amp; SUPPLIES (cont.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile saline for irrigation</td>
<td>2 liters</td>
<td>2 liters</td>
</tr>
<tr>
<td>Potable water</td>
<td>2 liters</td>
<td>2 liters</td>
</tr>
<tr>
<td>Bandage shears</td>
<td>1 pr</td>
<td>1 pr</td>
</tr>
<tr>
<td>S-SV EMS Agency approved commercial tourniquet device (optional)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| **IV / MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES** | | |
| Catheter over needle- 14ga, 16ga, 18ga, 20 ga | 6 each | 4 each |
| Catheter over needle- 22ga, 24ga | 2 each | 2 each |
| Micro-drip & Macro-drip venosets OR Selectable drip tubing | 4 each | 2 each |
| Blood administration tubing (optional) | 2 | 2 |
| IV extension | 4 | 2 |
| IV start pack or equivalent with tourniquets | 4 | 4 |
| Alcohol wipes & Betadine swabs | 20 each | 10 each |
| Chlorhexidine swabs/skin prep | 5 each | 5 each |

| **Syringes / Needles / Medication Administration Devices** | | |
| TB / 1 cc syringe | 3 | 2 |
| 3 - 5 cc syringe | 3 | 2 |
| 10 - 12 cc syringe | 3 | 2 |
| 20 cc syringe | 1 | 1 |
| 50 - 60 cc syringe | 1 | 0 |
| 22ga, 25 ga safety injection needles | 2 each | 2 each |
| Vial Access Cannulas | 2 each | 2 each |
| Mucosal Atomization Device (MAD) | 4 | 2 |

| **Miscellaneous IV / Medication Administration Equipment & Supplies** | | |
| Arm boards - (short, long) | 2 each | 1 each |
| Blood Tubes / Vacutainer holder / needles (optional) | (Optional) | (Optional) |
| Vials or pre-filled syringes - Sterile Normal Saline for injection (optional) | 2 | 2 |

| **IV SOLUTIONS** | | |
| Normal saline - 1000 cc bag | 8 | 3 |
| Normal saline - 250 cc bag | 2 | 1 |

| **MEDICATIONS** | | |
| Activated charcoal (50 gm) | 1 | 1 |
| Albuterol | 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5cc, without preservatives, is required for dilution of each dose. | 3 | 2 |
| Aspirin (chewable) | 1 bottle | 1 bottle |
| Atropine (1.0 mg/10ml) | 6 | 6 |
| Atropine 10mg multidose vials (optional) | (Optional) | (Optional) |
| Dextrose 50% (25gm/50ml) | 2 | 2 |
| Dextrose 25% (12.5gm/10ml) | 2 | 1 |
| Epinephrine 1:1,000 | 4 mg | 2 mg |
| Epinephrine 1:10,000 (1mg/10ml) | 8 | 4 |
| Furosemide 40 mg (10mg/ml) | 2 | 2 |
| Glucagon 1mg (1unit) | 1 | 1 |
| Glucose paste OR Glucose solution (oral prepackaged) | 2 | 2 |
| Lidoocaine 100 mg | 6 | 3 |
| Narcan (Naloxone) 2.0 mg | 4 | 4 |
| Nitroglycerin 0.4 mg/tab (1/150) bottle OR Nitroglycerine spray actuation | 2 | 1 |
| Sodium Bicarbonate (50mEq/50ml) | 2 | 1 |

| **Controlled Substances** | | |
| Midazolam (Versed) | 5 mg/cc concentration | 20 - 60 mg | 20 - 60 mg |
| Morphine HCL | 10 mg/ml unit dose | 20-60 mg | 20-60 mg |
| Double lock container system for controlled meds. | 1 | 1 |
| Controlled substance log sheet | 1 | 1 |

*Updated 12/01/2010*
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<tr>
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<td>Do Not Resuscitate (DNR). Including CMS Prehospital DNR Form and POLST form</td>
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<tr>
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</tr>
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</tr>
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</tr>
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</tr>
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</tr>
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<td>Medical Control for Transfers Between Acute Care Facilities</td>
</tr>
<tr>
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<td>Intravenous Infusion of Magnesium Sulfate, Nitroglycerin, Heparin &amp; / or Amiodarone During Interfacility Transports</td>
</tr>
</tbody>
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## SIERRA-SACRAMENTO VALLEY EMS AGENCY

**FIELD POLICIES & TREATMENT PROTOCOLS**

**SECTION VIII**

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<td>860-A</td>
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</tr>
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</tr>
</tbody>
</table>

### Adult Patient Treatment Protocols (BLS/ALS)

**Cardiovascular**

- **C-1** Pulseless Arrest
- **C-5** Return of Spontaneous Circulation
- **C-6** Tachycardia with Pulses
C-7 Bradycardia
C-8 Chest Pain / Discomfort of Suspected 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-6 General Medical Treatment
M-7 Nausea / Vomiting (From Any Cause)

**Neurological**
N-1 Altered Level of Consciousness
N-2 Seizure
N-3 Suspected CVA / Stroke

**Obstetric/Gynecology**
OB/G-1 Childbirth

**Environmental**
E-1 Heat Stress Emergencies: Hyperthermia
Subject: Index

E-2  Cold Stress Emergencies: Hypothermia
E-3  Frostbite
E-7  Hazardous Material Exposure
E-8  Nerve Agent Treatment

Trauma

T-1  General Trauma Management
T-2  Tension Pneumothorax
T-6  Isolated Extremity Injury – Including Hip or Shoulder Injuries
T-8  Uncontrolled Extremity Bleeding
T-10  Burns Thermal & Electrical

Pediatric Patient Treatment Protocols (BLS / ALS)

P-1  General Pediatric Protocol
P-2  Newborn Resuscitation
P-3  Apparent Life Threatening Event (ALTE)
P-4  Pulseless Arrest
P-6  Bradycardia – With a pulse causing Cardiorespiratory Compromise
P-8  Tachycardia with Pulses & Poor Perfusion
P-10  Foreign-Body Airway Obstruction
P-12  Respiratory Arrest
P-14  Respiratory Distress: Wheezing
P-16  Respiratory Distress: Stridor
P-18  Allergic Reaction / Anaphylaxis
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P-20 Shock
P-22 Overdose &/or Poisoning
P-24 Altered Level of Consciousness
P-26 Seizure
P-28 Burns Thermal & Electrical
P-30 Isolated Extremity Injury – Including Hip and Shoulder Injuries
P-32 Nausea / Vomiting (From Any Cause)
P-34 Uncontrolled Extremity Bleeding

Adult Patient Treatment Protocols (LALS)

Cardiovascular (LALS)
C-1 Pulseless Arrest
C-5 Return of Spontaneous Circulation
C-6 Tachycardia with Pulses
C-7 Bradycardia
C-8 Chest Pain / Discomfort of Suspected Cardiac Origin

Respiratory (LALS)
R-1 Airway Obstruction
R-2 Respiratory Arrest
R-3 Acute Respiratory Distress

Medical (LALS)
M-1 Allergic Reaction / Anaphylaxis
M-2 Shock / Non-Traumatic Hypovolemia
M-5 Ingestions and Overdoses
M-6 General Medical Treatment

**Neurological (LALS)**
N-1 Altered Level of Consciousness
N-2 Seizure
N-3 Suspected CVA / Stroke

**Obstetrics / Gynecology (LALS)**
OB/G-1 Childbirth

**Environmental (LALS)**
E-1 Heat Stress Emergencies: Hyperthermia
E-2 Cold Stress Emergencies: Hypothermia
E-3 Frostbite
E-7 Hazardous Material Exposure
E-8 Nerve Agent Treatment

**Trauma (LALS)**
T-1 General Trauma Management
T-6 Isolated Extremity Injury: Including Hip or Shoulder Injuries
T-8 Uncontrolled Extremity Bleeding
T-10 Burns Thermal & Electrical

**Pediatric Patient Treatment Protocols (LALS)**
P-1 General Pediatric Protocol
SIERRA-SACRAMENTO VALLEY EMS AGENCY

FIELD POLICIES & TREATMENT PROTOCOLS

SECTION VIII

SUBJECT: INDEX

REFERENCE NO. 800

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P-8  Tachycardia with Pulses & Poor Perfusion
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P-34 Uncontrolled Extremity Bleeding
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SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) SCOPE OF PRACTICE

PURPOSE:

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

AUTHORITY:

California Health & Safety Code, Division 2.5, Sections 1797.176, 1797.182 & 1797.204.

California Code of Regulations, Title 22, Division 9.

California EMS Authority Scope of Practice Position Statements, July 2010


POLICY:

A. While at the scene of an emergency or while assisting other EMS personnel during transport of the sick or injured, a certified EMR 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 the assessment of temperature, blood pressure, pulse and respiration rates, level of consciousness, and pupil status.

4. Perform cardiopulmonary resuscitation (CPR).

5. Use the following adjunctive airway breathing aids:

   a. oropharyngeal airway;
   b. nasopharyngeal airway;
   c. manual or mechanical suction devices; and
   d. manual ventilating devices designed for prehospital use (i.e. bag valve mask).
6. Administer supplemental oxygen therapy by nasal cannula, non-rebreather mask or in conjunction with a manual ventilation device.

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

8. Provide initial prehospital emergency care of trauma.


10. Perform field triage.

11. Perform automated external defibrillation when authorized by an AED service provider.
SUBJECT: HAZARDOUS MATERIALS INCIDENTS

PURPOSE:

This policy establishes guidelines for the response of ambulance transport providers to incidents involving Hazardous Materials (Haz Mat) or Weapons of Mass Destruction (WMD).

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.150, 1797.151, 1797.204, 1797.214, 1798.6.

California Code of Regulations, Title 22, Sections 100172 and 100175.

DEFINITIONS:

Hazardous Materials are classified as any material which is explosive, flammable, poisonous, corrosive, reactive, or radioactive, or any combination, and requires special care in handling because of the hazards it poses to public health, safety, and/or the environment.

Hazardous Materials (Haz Mat) Response Team – Is an emergency team that has received specialized training and equipment for the purpose of protecting the public and the environment in the event of a accidental or intentional release of Hazardous materials into the environment.

Emergency Decontamination – An emergency procedure for the removal of contamination from an exposed victim requiring immediate lifesaving care.

Planned Decontamination – The procedures in place for the Haz Mat Response Team to perform decontamination at a hazardous materials incident.

Mass Decon - Decontamination of the greatest number of people possible with available resources. Normally accomplished by emergency decon followed by full decon.

Exclusion Zone (Hot Zone) - Area that encompasses all known or suspected hazardous materials
SUBJECT: HAZARDOUS MATERIALS INCIDENTS

Contamination Reduction Zone (Warm Zone) - Area between the "Exclusion Zone" and the "Support Area". "Safe Refuge Area" and "Contamination Reduction Corridor" are set up within this area.

Contamination Reduction Corridor - An area within the "Contamination Reduction Zone" where the actual decontamination takes place. EMS personnel, once cleared, receive patients at the end of the "Contamination Reduction Corridor" and move them to the "Support Area" for secondary treatment.

Support Zone (Cold Zone) - Clean area outside "Contamination Reduction Zone" where equipment and rescue personnel are staged to receive and treat decontaminated patients. Secondary exposure to hazardous materials is not expected in this area and special clothing is not required.

TRAINING AND COMPETENCY:

According to CCR, Title 8, Section 5192, the minimum training for EMS responders shall be Haz Mat First Responder Awareness level. Annual refresher training is required to be provided by the employer to be of sufficient content and duration to maintain competencies or to demonstrate those competencies. Additional training may be required to function at an emergency.

POLICY:

The responsibility for hazardous material containment, identification, decontamination, and victim evacuation rests with the Incident Commander of the fire and/or law enforcement agencies having primary investigative authority.

A. The management structure utilizes the Incident Command System. All resources ordered for Haz Mat incident shall be committed to the incident until released by the Incident Commander.

B. Avoid contamination – accept only decontaminated patients. Do not transport contaminated patients without Incident Commander approval and appropriate personal protective equipment.

Exception: For radiation contaminated patients that meet immediate triage criterion, treatment and transport will not be delayed for decontamination processes

C. Do NOT enter the Exclusion Zone. EMS personnel will not use personal protective equipment / breathing apparatus unless they have been specifically trained in its use prior to the incident.

D. Contact the base/modified base or receiving hospital as soon as possible in an incident, so they may prepare to receive victims. The base/modified base hospital should assist field personnel determine a decontamination and treatment plan.
SUBJECT: HAZARDOUS MATERIALS INCIDENTS

DISPATCH:

Units dispatched to a possible hazardous materials incident shall be advised by dispatch (in addition to the usual information) of the following:

A. On scene wind direction and recommended approach route; coordinated with Incident Commander.

B. Staging Area location.

C. Location of Incident Commander Post (if established).

D. Communication frequencies

E. Type of hazardous material(s) involved (if known).

F. Estimated number of patients.

SCENE MANAGEMENT:

Ambulances will approach cautiously and park upwind, uphill and upstream from the incident using the Emergency Response Guidebook (ERG) as a guide for the distance to park from the incident.

Observe wind and/or plume direction, if applicable.

Initial Ambulance is first on scene:

A. If first on scene, assume incident command until otherwise established.

   1. First provide for your own safety.
   2. Isolate scene and Deny entry (keep others away!). Move uninvolved victims to a safe zone.
   3. Notify dispatch and the base/modified base hospital that it is a Haz Mat scene. Ensure notification of local Haz Mat resources utilizing local procedures for hazardous materials incidents.
   4. Coordinate with other public safety personnel as they arrive on scene to establish the ICS.

B. Confirm HAZ MAT using DOT Emergency Response Guidebook and notify appropriate authorities. Reconfirm HAZ MAT with other references and resources if available.

Initial Ambulance – first responders already on scene:

A. If upon arrival of the first ambulance, the first responders have determined or have suspicion of a hazardous material incident, ambulance providers will coordinate with other public safety personnel on scene to establish the ICS.
B. If the ICS has been established, ambulance personnel shall report to the IC or staging area manager upon arrival on scene.

**Arrival at a known Hazardous Material scene:**

At no time shall EMS personnel enter the scene of a known Haz Mat incident without the clearance from the IC or designee. Once the support zone is established, the responding EMS unit(s) will stage as directed by the IC or designee. Once at scene, in coordination with the IC or designee, EMS will provide treatment and transport of patient(s) after decontamination is completed, with the exception of radiation incidents (See exception for radiation contamination under policy section, B).

**Recognition of a Hazardous Material on-scene or during transport:**

If EMS personnel become aware of Hazardous Materials while on scene or during transport:

A. Request Haz Mat response from appropriate jurisdictional authority.

B. Personnel shall consider themselves contaminated and part of the incident (HOT ZONE), and consider self-decontamination.

C. Evacuate to a safe location to minimize exposure and notify EMS Dispatch of the potential contamination. If identified during transport, notify dispatch of contamination and await direction.

D. Request closest fire and law enforcement agencies response to the scene for site control and emergency decontamination.

**PATIENT CARE:**

A. EMS personnel shall not attempt to enter any Haz Mat scene or render medical care beyond the support zone without the specific direction from the Incident Commander or designee. **ONLY appropriately trained prehospital personnel utilizing appropriate Personnel Protective Equipment (PPE) shall perform treatment within the “HOT” and “WARM” zones.**

B. Medical treatment and transportation is secondary to the prevention of spreading the contaminate, and the management of the Hazardous Materials incident. The Incident Commander or designee is responsible for determining the treatment priority for the patient(s). EMS transport personnel may be requested to receive non-ambulatory patients from the Contamination Reduction Zone after decontamination has been completed.

C. For radiation contaminated patients that meet immediate triage criteria, treatment and transport will not be delayed for decontamination processes.
D. EMS personnel may only provide and/or initiate patient care after the patient has been transferred to them in the designated area as deemed by the incident commander.

E. Deceased victims shall be left undisturbed at the scene, or moved at the direction of the coroner, Incident Commander or designee.

F. The use of EMS helicopters for the transport of potentially contaminated Haz Mat patient(s), or WMD is generally, NOT APPROPRIATE. Patient transport by helicopter shall occur only by direction of the IC or designee. EMS helicopters may be utilized at the discretion of the IC, or designee to transport immediate, radiation contaminated patients under the same criteria as ground based transportation assets.

G. Advise the base/modified base hospital of material involved and request direction for treatment.

H. If necessary, request CHEMPACK resources utilizing county specific activation procedures.

I. Treat as directed by specific S-SV EMS protocol, and/or the base/modified base hospital.

1. Decontamination as directed, if trained and properly equipped.
2. Determine effectiveness of decontamination.
3. ABC’s.
4. Oxygen and ventilate as needed.
5. Cover the patient and consider modesty when possible. Warming measures as needed after decontamination.

J. Procedures and treatment as clinically indicated and per base/modified base hospital order.

K. For specific treatments see S-SV EMS Agency protocols as follows:

1. Chemical burns, Organophosphate or Carbamate pesticides, and Hydrofluoric Acid see Hazardous Material Exposure protocol E-7
2. Nerve Agent Exposure see Nerve Agent Treatment protocol E-8

CROSS REFERENCES

Policy and Procedure Manual

Ingestions and Overdoses, Reference No. M-5
Hazardous Material Exposure, Reference No. E-7
Nerve Agent Treatment, Reference No. E-8
EMERGENCY RESPONSE GUIDEBOOK
INTRODUCTION:

The Sierra-Sacramento Valley Emergency Medical Services Agency serves a multi-county area in California State 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 Cal-EMA Mutual Aid 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 hospital responsible for the dispersal of patients during all Multi-Casualty Incidents. The designated Control Facilities for the S-SV EMS Region are listed in Policy Reference No. 505-A ‘Hospital Capabilities’.
SUBJECT: MULTIPLE PATIENTS/CASUALTY INCIDENTS

POLICY:

A. The OES Region IV MCI Plan shall be used as a standard for training and managing MCIs within the S-SV EMS Region until such time that an equivalent Region III MCI plan is developed and approved. This plan details the procedures for MCI response in the field (Manual 1), at the CF (Manual 2), and at the operational area and regional levels (Manual 3). Counties in Region IV will use all three manuals. Counties in Region III will use Manuals 1 and 2 until such time that an equivalent Region III MCI plan is developed and approved, and follow their local and regional protocols for local government, operational area, and regional assistance.

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:

- Five (5) or more Immediate and/or Delayed patients from a unifocal incident, or
- Ten (10) or more Minor patients from a unifocal incident, irrespective of the number of Immediate and/or Delayed patients, or
SUBJECT: MULTIPLE PATIENTS/CASUALTY INCIDENTS

- At the discretion of the EMS provider(s) on scene or the base/modified base hospital.

CROSS REFERENCES:

Policy and Procedure Manual

S-SV EMS Region Hospital Capabilities, Reference No. 505-A

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

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
### Activation Triggers

Incident conditions significantly impact or overwhelm hospital or prehospital resources, which may include one or more of the following:

- Five (5) or more Immediate and/or Delayed patients from a unifocal incident, or  
- Ten (10) or more Minor patients from a unifocal incident, irrespective of the numbers of Immediate and/or Delayed patients, or  
- At the discretion of the EMS provider(s) on scene or the base/modifying base hospital.

### Command & Control

A. The Incident Commander (IC) shall be that 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.

B. The IC may directly supervise operations or appoint an Operations Section Chief.

C. The first-in medical responders should be appointed Medical Group Supervisor (MGS) and Triage Unit Leader.

### Initial Responders

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:

- **Resources**: 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.

- **Assignments**: Assign Triage Unit Leader to begin triage.

- **Communications**: Dispatch will assign frequencies (i.e. tactical, command, air operations) for the incident. Clarify with the IC if necessary.

- **Ingress/Egress**: Determine the best routes in and out of the incident in cooperation with the IC, and notify dispatch if appropriate.

- **Name**: Incident name will normally be assigned by dispatch. Clarify incident name with the IC if necessary.

- **Geography**: Quickly determine with the IC where staging, triage, treatment and transport areas will be established.

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.
# Subject: MCI – Response Procedures

<table>
<thead>
<tr>
<th>Triage</th>
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<tbody>
<tr>
<td>A. S.T.A.R.T. triage shall be used.</td>
<td>Triage tags shall be applied to each patient.</td>
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<tr>
<td>B. Personnel should spend no more than 30-60 seconds per patient triaging.</td>
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<tr>
<td>C. Treatment rendered will initially be confined to airway positioning and major hemorrhage control.</td>
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<td>D. 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>
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<thead>
<tr>
<th>Treatment</th>
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<tbody>
<tr>
<td>A. Designate Treatment Areas as needed:</td>
<td>Immediate (Red), Delayed (Yellow), and Minor (Green). These</td>
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<tr>
<td></td>
<td>areas should be located in safe areas, large enough to handle</td>
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<td></td>
<td>the number of victims, easily accessible to patient transport</td>
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<td></td>
<td>vehicles, and away from the Morgue Area (Black).</td>
</tr>
<tr>
<td>B. Once initial triage has been completed,</td>
<td>patients may be sent to the appropriate treatment area.</td>
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<td></td>
<td>Continuous re-triage and patient evaluation should occur in</td>
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<td>these areas until the patient is transported.</td>
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<tr>
<td>C. Personnel assigned to the treatment</td>
<td>areas shall only function within their scope of practice.</td>
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<tr>
<td>D. Any on-scene MD’s and RN’s should be</td>
<td>assigned to the treatment areas.</td>
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<thead>
<tr>
<th>Transportation</th>
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<tbody>
<tr>
<td>A. If a staging area has been established,</td>
<td>transport crews shall remain with their vehicle in the staging</td>
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<td></td>
<td>area until requested to the scene.</td>
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<tr>
<td>B. The Patient Transportation Unit Leader</td>
<td>(or Medical Communications Coordinator if established), in</td>
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<tr>
<td>(or Medical Communications Coordinator if</td>
<td>cooperation with the CF will arrange transport of patients</td>
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<tr>
<td>established), in cooperation with the CF</td>
<td>to the most appropriate facilities.</td>
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<td></td>
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<tr>
<td>C. At all times the most immediate patients</td>
<td>should be transported first to the most appropriate available</td>
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<td></td>
<td>medical facility.</td>
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<tr>
<td>D. Patients may be transported by a lower</td>
<td>level of trained personnel as determined by the Patient</td>
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<td></td>
<td>Transportation Unit Leader in cooperation with Treatment Area</td>
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<td></td>
<td>Managers based on available resources and personnel.</td>
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<tr>
<td>E. The Patient Transportation Unit Leader</td>
<td>(or Medical Communications Coordinator if established) will</td>
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<td>(or Medical Communications Coordinator if</td>
<td>contact the CF and provide patient information, and total</td>
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<td>established) will contact the CF and</td>
<td>number of transport resources available. Patient information</td>
</tr>
<tr>
<td></td>
<td>will be limited to age, gender, triage category, triage tag</td>
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<td></td>
<td>number, and major injury.</td>
</tr>
<tr>
<td>F. The CF will relay patient information to</td>
<td>the receiving facilities.</td>
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<td></td>
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</tr>
<tr>
<td>G. Non-traditional transport resources (e.g.</td>
<td>buses, vans) may be used on large scale incidents when</td>
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<td>appropriate, in consultation with the CF. Appropriate EMS</td>
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<tr>
<td></td>
<td>personnel must accompany patients transported by these</td>
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<td>non-traditional transport resources.</td>
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</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.
### 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).

### TRIAGE 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).

### TREATMENT UNIT LEADER

- Develop organization sufficient to handle assignment.
- Direct and supervise Treatment Dispatch, Immediate, Delayed, & Minor Treatment Areas.
- Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- Request sufficient medical caches and supplies as necessary.
- Establish communications and coordination with Patient Transportation Unit Leader.
- Ensure continual triage of patients throughout Treatment Areas.
- Direct movement of patients to ambulance loading area(s).
- Give periodic status reports to Medical Group Supervisor.
- 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)
<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>• Advise Medical Communications Coordinator of patient readiness and priority for transport.</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>• Coordinate transportation of patients with Medical Communications Coordinator.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>MORGUE MANAGER</th>
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</thead>
<tbody>
<tr>
<td>• Assess resource/supply needs and order as needed.</td>
<td>• Assure that appropriate patient tracking information is recorded.</td>
</tr>
<tr>
<td>• Coordinate all Morgue Area activities.</td>
<td>• Coordinate ambulance loading with the Treatment Managers and ambulance personnel.</td>
</tr>
<tr>
<td>• Keep area off limits to all but authorized personnel.</td>
<td>• Maintain Unit/Activity Log (ICS Form 214)</td>
</tr>
<tr>
<td>• Coordinate with law enforcement and assist the Coroner or Medical Examiner representative.</td>
<td></td>
</tr>
<tr>
<td>• Keep identity of deceased persons confidential.</td>
<td></td>
</tr>
<tr>
<td>• Maintain appropriate records.</td>
<td></td>
</tr>
</tbody>
</table>
SUBJECT: INTRAVENOUS INFUSION OF MAGNESIUM SULFATE, NITROGLYCERIN, HEPARIN &/OR AMIODARONE DURING INTERFACILITY TRANSPORTS

PURPOSE:

To provide a mechanism for paramedics to be permitted to monitor infusions of magnesium sulfate, nitroglycerin, heparin and/or amiodarone during interfacility transports.

AUTHORITY:

Division 2.5, Health and Safety Code, Sections 1797.220

California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

A. Only those paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director on magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions will be permitted to monitor them during interfacility transports.

B. Only those ALS ambulance providers approved by the S-SV EMS Agency Medical Director will be permitted to provide the service of monitoring magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions during interfacility transports.

C. Patients that are candidates for paramedic transport will have pre-existing magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions in peripheral or central IV lines. Prehospital personnel will not initiate magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusions. The magnesium sulfate, nitroglycerin, heparin and/or amiodarone infusion will have been running for at least 10 minutes prior to transport. Patients will have maintained stable vital signs for the previous 30 – 60 minutes and will not have more than two medication infusions running exclusive of potassium chloride (KCl). The timeframes listed above will not apply to patients who require immediate transport for critical interventions when the transferring and/or receiving physician(s) determine that immediate transport is in the best interest of patient care.

D. Magnesium sulfate infusions are only approved for patients with suspected pre-eclampsia.
SUBJECT: INTRAVENOUS INFUSION OF MAGNESIUM SULFATE, NITROGLYCERIN, HEPARIN &/OR AMIODARONE DURING INTERFACILITY TRANSPORTS

PROCEDURE:

A. All patients will be maintained on a cardiac monitor and a non-invasive blood pressure monitor.

B. The paramedic shall receive the transferring orders from the transferring physician prior to leaving the sending hospital, including a telephone number where the transferring physician can be reached during the patient transport. Transferring physicians must be aware of the general scope of practice of paramedics and the transport protocol parameters outlined below. The written orders must include the type of solution, dosage and rate of infusion for the IV fluids.

C. Patients will be hemodynamically stable at the time of transport and will not have more than two medication infusions running exclusive of KCl.

D. Patients will meet pre-established criteria for hemodynamic stability, as noted by the transferring physician on the magnesium sulfate, nitroglycerin, heparin and / or amiodarone transferring orders.

E. If medication administration is interrupted (infiltration, accidental disconnection, malfunctioning pump, etc.), the paramedic may restart the line as delineated in the transfer orders.

F. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the paramedic. In cases of pump malfunction that cannot be corrected, the medication drip will be discontinued and the transferring physician and base hospital notified as soon as possible. The S-SV EMS Agency Medical Director shall be notified of the pump malfunction within 24 hours.

G. The paramedic shall document on the patient care report (PCR) the total volume infused throughout the duration of the transport.

1. MAGNESIUM SULFATE INFUSIONS

Paramedics are allowed to transport patients on magnesium sulfate infusions within the following parameters:

a. Infusion fluid will be NS. Medication concentration will be 10Gms/100mL.

b. Regulation of the infusion rate will be within parameters defined by the transferring physician.

c. If patient develops signs of magnesium toxicity, the medication drip will be discontinued and the transferring physician and base hospital will be notified.

d. Signs of magnesium toxicity include:
SUBJECT: INTRAVENOUS INFUSION OF MAGNESIUM SULFATE, NITROGLYCERIN, HEPARIN &/OR AMIODARONE DURING INTERFACILITY TRANSPORTS

- Thirst
- Diaphoresis
- DTR’s (Deep Tendon Reflexes)- depressed or absent
- Hypotension
- Flaccid paralysis
- Respiratory depression
- Circulatory depression or collapse
- CNS depression
- Urine output < 30 ml/hr
- Chest pain or pulmonary edema

e. Vital signs will be monitored and documented every 15 minutes and immediately if there is any change in patient status or change in medication adjustment.

2. NITROGLYCERIN INFUSIONS

Paramedics are allowed to transport patients on nitroglycerin infusions within the following parameters:

a. Infusion fluid will be D5W. Medication concentration will be 50mg/250mL.

b. Regulation of the infusion rate will be within parameters defined by the transferring physician, but in no case will changes be greater than 10mcg/minute increments every 5-10 minutes. In cases of severe hypotension, the medication drip will be discontinued and the transferring physician and base hospital will be notified.

c. Discuss with transferring physician concomitant use of analgesics during transport, e.g. IV morphine sulfate.

d. Vital signs will be monitored and documented every 15 minutes and immediately if there is any change in patient status or change in medication adjustment.

3. HEPARIN INFUSIONS

Paramedics are allowed to transport patients on heparin infusions within the following parameters:

a. Infusion fluid will be D5W or saline. Medication concentration will be 100units/mL of IV fluid (25,000 units/250mL).

b. Infusion rates will remain constant during transport. No regulation of the rate will be performed except to turn off the infusion completely.
c. Infusion rates will not exceed 1600 units/hour.

d. Vital signs will be monitored and documented every 15 minutes.

4. AMIODARONE HYDROCHLORIDE INFUSIONS

Paramedics are allowed to transport patients on amiodarone infusions within the following parameters:

a. Medication concentration must be a minimum concentration of 150mg/250mL (0.6 mg/mL); medication is unstable in more dilute solutions.

b. Infusion rates must remain constant during transport with no regulation of rates being performed by the paramedic, except for the discontinuation of the infusion.

c. Infusion rates may vary between 0.25 – 1 mg/min.

d. Vital signs will be monitored and documented every 15 minutes.

e. Y-Injection incompatibility; the following will precipitate with amiodarone hydrochloride:
   
   - Heparin
   - Sodium Bicarbonate

f. Amiodarone hydrochloride intravenous infusion monitoring is not approved for patients < 14 years old without base / modified base physician contact.

g. For infusions > one hour, amiodarone hydrochloride concentrations should not exceed 2mg/mL unless a central venous catheter is used.

CONTINUOUS QUALITY IMPROVEMENT (CQI):

All calls will be audited by the provider agency CQI process. Audits will assess compliance with physician orders and regional protocols, including base hospital contact in emergency situations. Reports will be sent to the EMS Agency as requested.

CROSS REFERENCES:

Prehospital Care Policy Manual

Paramedic Interfacility Transport Optional Skills: Transferring Hospital Requirements, Reference No. 341
SUBJECT: INTRAVENOUS INFUSION OF MAGNESIUM SULFATE, NITROGLYCERIN, HEPARIN &/OR AMIODARONE DURING INTERFACILITY TRANSPORTS

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
SUBJECT: MONITORING OF PRE-EXISTING BLOOD TRANSFUSION DURING INTERFACILITY TRANSPORTS

PURPOSE:

To provide a mechanism for paramedics to be permitted to monitor pre-existing blood transfusions during interfacility transports.

AUTHORITY:

Division 2.5, Health and Safety Code, Sections 1797.220

California Code of Regulations, Title 22, Chapter 4, Article 1, Section 100145

POLICY:

A. Only those paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director on pre-existing blood transfusions will be permitted to monitor them during interfacility transports.

B. Only those ALS ambulance providers approved by the S-SV EMS Agency Medical Director will be permitted to provide the service of monitoring pre-existing blood transfusions during interfacility transports.

C. Paramedic monitoring of pre-existing blood transfusions during interfacility transports is limited to those circumstances when there are no RN staffed Critical Care Transport (CCT) units available and/or when air ambulance transport is not appropriate or available.

D. Patients who are candidates for paramedic transport will have pre-existing blood transfusions in peripheral or central IV lines. Prehospital personnel will not initiate blood transfusions.

PROCEDURE:

A. All patients will be maintained on a cardiac monitor and a non-invasive blood pressure monitor.

B. The paramedic shall receive the transferring orders from the transferring physician prior to leaving the sending hospital, including a telephone number where the transferring physician can be reached during the patient transport. Transferring
physicians must be aware of the general scope of practice of paramedics and the transport protocol parameters outlined in this policy. The written orders must include the transfusion rate.

C. Patients will be hemodynamically stable at the time of transport.

D. Paramedic personnel must be knowledgeable in the operation of the specific Blood delivery/warming device(s).

E. Regulation of the transfusion rate will be within the parameters defined by the transferring physician.

F. Identify the patient and blood by checking the patient ID band against the blood label and blood order for name, blood type and unit identifying number.

G. Vital signs will be monitored and documented every 15 minutes and immediately if there is any change in patient status or change in transfusion rate.

H. Monitor the patient for any signs and symptoms of a transfusion reaction. Monitor temperature for adverse effects if transport time exceeds 15 minutes. The following are the most common types of transfusion reactions that may occur:

**Hemolytic reactions:** Hemolytic reactions are the most life-threatening. Clinical manifestations may vary considerably: fever, headache, chest or back pain, pain at infusion site, hypotension, nausea, generalized bleeding or oozing from surgical site, shock. The most common cause is from ABO incompatibility due to a clerical error or transfusion to the wrong patient. Chances of survival are dose dependent therefore it is important to stop the transfusion immediately if a hemolytic reaction is suspected. Give a fluid challenge of NS. See shock protocol (M-2).

**Febrile non-hemolytic reaction:** Chills and fever (rise from baseline temperature of 1°C or 1.8°F). Document and report to hospital on arrival.

**Allergic reaction:** Characterized by appearance of hives and itching (urticaria or diffuse rash). See allergic reaction / anaphylaxis protocol (M-1)

**Anaphylaxis:** May occur after administration of only a few ml's of a plasma containing component. Symptoms include coughing, bronchospasm, respiratory distress, vascular instability, nausea, abdominal cramps, vomiting, diarrhea, shock, and loss of consciousness. See allergic reaction / anaphylaxis protocol (M-1).

**Volume overload:** Characterized by dyspnea, headache, peripheral edema, coughing, frothy sputum or other signs of congestive heart failure occurring during or soon after transfusion. Restrict fluid.
If a transfusion reaction occurs:

- Stop the transfusion immediately.
- Contact transferring physician and base / modified base hospital.
- Consult appropriate treatment protocol.
- Document any transfusion reactions.
- Report to hospital immediately upon arrival.

I. The paramedic shall document on the patient care report (PCR) the total volume infused throughout the duration of the transport.

CONTINUOUS QUALITY IMPROVEMENT (CQI):

All calls will be audited by the provider agency CQI process. Audits will assess compliance with physician orders and regional protocols, including base hospital contact in emergency situations. Reports will be sent to the EMS Agency as requested.

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

Allergic Reaction / Anaphylaxis, Reference No. M-1

Shock / Non-Traumatic Hypovolemia, Reference No. M-2
SUBJECT: PATIENT INITIATED RELEASE AT SCENE (RAS) OR REFUSAL OF SERVICE AGAINST MEDICAL ADVICE (AMA)

PURPOSE:

To provide directions and guidelines when a patient declines transport by ambulance to an acute care hospital, while respecting the rights of a competent person to make prudent healthcare decisions. To provide direction and guidelines when a patient refuses emergency medical assessment, treatment and / or transportation. Patients requesting ambulance transport shall not be denied transport under this policy.

AUTHORITY:

California Health & Safety Code, Division 2.5, Sections 1797.204, 1797.220, and 1798 et seq.

California Code of Regulations, Title 22, Division 9

Welfare and Institutions Code, Section 5008, 5150 and 5170

DEFINITIONS:

Person – Any competent individual encountered by EMS personnel who upon questioning, denies illness or injury and does not exhibit any evidence of illness or injury. The individual did not call 911 or direct 911 to be called for a medical complaint.

Patient – Any person encountered by EMS personnel who upon questioning, requests assessment, treatment or transport or appears to exhibit evidence of illness or injury.

Competent Person / Patient – An individual with a capacity to understand the nature of his / her medical condition, if one exists, and is not impaired by alcohol, drugs / medications, mental illness, traumatic injury, grave disability or mental abilities diminished due to age.

Gravely Disabled – A condition in which a person, as a result of a mental disorder or impairment by intoxication, is unable to provide for his / her basic personal needs for food, clothing and shelter (Welfare and Institutions Code, Section 5008). Persons who are 21 years of age or older who have organic brain syndrome, dementia, Alzheimer type conditions or other organic brain disorders may qualify for involuntary hospitalization if they are a danger to self / others or gravely disabled.
**5150 W & I – When any person, as a result of a mental disorder is a danger to others or to him / herself or is gravely disabled; a peace officer or a member of the attending staff (as defined by regulation) of an evaluation facility designated by the County or members of a mobile crisis team or other professional person designated by the County may, upon probable cause take, or cause to be taken, the person into custody and place him / her in a facility designated by the County and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. (Welfare and Institutions Code, Section 5150)**

**POLICY:**

**Patient Refusal of Service: Released at Scene**

A. Patients who are released at scene by EMS personnel must be a competent adult, a minor not requiring parental consent (Reference Policy 851) or a minor in compliance with Section C: MINORS below and meet **ALL** of the following:

1. The patient or guardian must have a clearly articulated plan for medical assessment and/or follow-up if necessary that relies on previously established medical providers or the use of recognized acute care/urgent providers and facilities.

2. This plan must have a reasonable and prudent transportation plan to reach follow-up medical care in a timely manner if necessary.

3. After a complete assessment, the highest medical authority on scene must concur with the appropriateness of scene release and the medical appropriateness of the follow-up plan.

4. The Incident Commander (IC) should be consulted and concur with the non-medical aspects of the follow-up plan.

5. The highest medical authority on scene shall instruct the patient or legal guardian and witness(es) to call 9-1-1 and/or seek immediate medical attention if the condition continues or worsens or if new symptoms develop.

B. Base/modified base contact shall be made by the highest medical authority on scene in close proximity to the patient prior to releasing the following classes of patients:

1. Patients, who the provider has knowledge of, who have been released at scene within the previous 24 hours.

2. Children 3 years of age or under.

3. Patients age 4 years to 17 years without a responsible adult signature.
Patients meeting the above criteria shall be assessed and offered treatment and transport by ALS / LALS personnel whenever possible. BLS personnel may only release at scene these classes of patients if ALS / LALS personnel are not available (i.e. extremely extended ETA of ALS, 9-1-1 BLS ambulance provider without ALS response).

C. MINORS

1. A minor who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

   a. Self, after base / modified base consult (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation)

   b. Parent or legal representative

   c. A responsible adult at the scene

   d. A designated caregiver

   e. Law enforcement

2. EMS personnel shall document on the Patient Care Report (PCR) to whom the patient was released.

3. Prior to releasing a minor to a responsible adult on scene who is not a parent, legal representative or designated caregiver, EMS personnel must verify the identity of the adult to whom the patient is being released. This verification (driver’s license number, other form of government ID, etc.) must be documented on the PCR. Involvement of law enforcement is required if a concern for child neglect or endangerment exists.

4. Base/modified base contact shall be required on:

   a. Patients 3 years old and under.

   b. Patients 4 years to 17 years old without a responsible adult signature.

5. If the minor is being released to himself/herself or a responsible adult on scene, EMS personnel shall attempt to contact the patient’s parent, legal representative, or designated caregiver prior to the release.

D. EMS personnel will NOT release at scene under this section of the policy the following classes of patients:

1. Patients who meet Trauma Triage Criteria.
2. Patients with ANY new onset medical complaints such as seizures, headache, hypoglycemia, respiratory distress or cardiac symptoms regardless of the duration of the complaint.

3. Patients who are difficult to assess, have altered mental status, OR whose baseline mental status is chronically altered due to a pre-existing condition such as Alzheimer’s disease, dementia or previous CVA.

4. Patients with a significant medical concern.

5. Patients meeting ALS / LALS treatment policy criteria.

6. Patients meeting criteria for ALTE.

7. Patients for whom EMS personnel does not feel comfortable with the termination of the EMS Personnel – Patient relationship

**Patient Refusal of Service: Against Medical Advice**

A. To legally refuse medical assessment, treatment and/or transportation against the medical advice of EMS personnel on scene, the patient must be a competent adult or minor not requiring parental consent (Reference Policy 851).

B. All AMA patients shall be assessed and offered treatment and transport by ALS / LALS personnel whenever possible. BLS personnel may only complete an AMA if ALS / LALS personnel are not available (i.e. extremely extended ETA of ALS, 9-1-1 BLS ambulance provider without ALS response).

C. Parents / legal guardians for minors / dependents may sign AMA but must be present at scene.

D. All AMA patients require the following steps:

1. Consider having other EMS personnel on scene offer assessment, treatment and/or transportation.

2. Involvement of law enforcement is required for the following patients:

   a. Any patient who presents with an altered level of consciousness and refuses care. Inappropriate hostility or aggressiveness should alert the care provider to the possibility that the patient’s thinking process may be impaired.

   b. Any patient refusing care who has attempted suicide or verbalizes suicidal/homicidal ideation.
c. A patient making a decision which is clearly irrational in the presence of a potentially life-threatening condition or has unstable vital signs and refuses care.

d. If the patient is less than 18 y/o and a concern for child neglect or endangerment exists.

e. A patient under a Welfare and Institutions Code 5150 hold.

Note: Patients may be detained against their will only when determined to be a danger to themselves or others or gravely disabled as defined by Welfare and Institutions Code section 5150. This determination must be done by law enforcement or a mental health care professional designated by the County.

If law enforcement refuses to assist in the facilitation of treatment and/or transport of a patient when indicated, EMS personnel should request that the officer on scene speak directly with the base / modified base MICN and/or physician regarding the necessity for patient treatment and/or transportation.

3. Base / modified base hospital contact is required for all AMAs. Communication with the base / modified base hospital should be in close proximity to the patient so that the MICN and/or physician can directly communicate with the patient or legal guardian to encourage him/her to consent to recommended assessment, treatment and/or transportation.

4. If the base / modified base hospital recommends additional involvement of law enforcement, adult or child protective services, the highest medical authority shall remain on scene until the patient is placed into or released from one of these special custody arrangements.

5. The highest medical authority on scene shall inform the patient or legal guardian and witness(es) of the adverse consequences of refusing indicated emergency medical assessment, treatment and/or transportation.

6. The highest medical authority on scene shall instruct the patient or legal guardian and witness(es) to call 9-1-1 and/or seek immediate medical attention if the condition continues or worsens or if new symptoms develop.

**Communication Failure**

In the event of communication failure, patients who require base / modified base hospital contact under this policy may be released after all other requirements are met. EMS personnel must document the method(s) of communication attempted and the reason for the communication failure.
**Documentation**

1. The highest medical authority on scene must document the following minimum information of a Patient Care Report for all RAS and AMA patients:

   a. The date and estimated time of incident.
   b. The time of receipt of the call.
   c. The time of dispatch to the scene.
   d. The time of arrival at scene.
   e. The location of the incident.
   f. The patient’s name, age, gender, weight if necessary for treatment and address.
   g. Chief complaint.
   h. Vital signs.
   i. Appropriate physical assessment.
   j. Any emergency care rendered and patient’s response to such treatment.
   k. That emergency assessment and/or treatment has been offered and/or rendered, transportation offered and that the patient or legal guardian chooses an alternate plan or is refusing indicated emergency medical assessment, treatment and/or transportation.
   l. In the event of communication failure for patients who require base / modified base contact under this policy, the method(s) of communication attempted and reason for the communication failure.
   m. Information on whom a minor patient was released on scene to if applicable.
   n. Patient disposition.
   o. The name(s) and unique identifier number(s) of the EMS personnel.
   p. Signature(s) (physical or electronic) of EMS personnel.

2. The patient or guardian shall sign the S-SV EMS Agency Refusal of Care Form (Reference No. 850-A), or an equivalent provider specific refusal of care form. If the patient or guardian refuses to sign, document the refusal and obtain a witness signature.

**Continuous Quality Improvement**

The provider will audit 100% of RAS and AMA patients released under this policy, based on available data, for medical appropriateness, compliance with department/company policy and compliance with S-SV EMS policies.

**CROSS REFERENCES:**

- Policy and Procedure Manual
- Cancellation or Reduction of ALS / LALS Response, Reference No. 848
- Treatment / Transport of Minors, Reference No. 851
Termination of EMS Personnel – Patient Relationship Algorithm

**PERSON**
- Did not call 911 or direct 911 to be called for a medical complaint
- Does not request assessment
- Does not have a significant mechanism of injury or illness
- Competent adult, minor not requiring consent, or individuals 4 to 17 y/o with parent/guardian/responsible adult
- Not intoxicated
- No altered mental status
- Document the circumstances surrounding reason for call
- Advise to call 911 if any change in condition or desire for transport
- No assessment documentation required
- No release signature required

**RAS**
- Has a minor injury or illness
- EMS personnel feel comfortable with termination of relationship
- Has a significant medical concern or mechanism of injury, including all ALS/LALS chief complaints or ALTE patients
- EMS personnel do not feel comfortable with termination of relationship
- Must be a competent adult or minor not requiring parental consent
- Parents/legal guardians for minors/dependents may sign AMA (must be present at scene)
- Base/modified base contact required for prior RAS within 24 hours
- RAS signature required
- Full assessment documentation required
- Advise patient/guardian the risks and benefits
- Advise to call 911 if any change in condition or desire for transport

**AMA**
- Base/modified base contact required
- AMA signature required
- Full assessment documentation required
- Advise patient/legal guardian the risks and benefits up to & including death
- Advise to call 911 if any change in condition or desire for transport
- If less than 18 y/o and concern for child endangerment exists, Law Enforcement shall be contacted
**S-SV EMS REFUSAL OF CARE FORM (850-A)**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>DOB</th>
<th>Date</th>
<th>Incident #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Base / Modified Base Hospital</th>
<th>Name of MICN and/or physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Released at Scene (RAS)</td>
<td>EMS Provider(s)</td>
</tr>
<tr>
<td>Refusing Against Medical Advice (AMA)</td>
<td></td>
</tr>
</tbody>
</table>

The following apply to myself or the patient on whose behalf I legally sign this document (check all that apply):

- I am refusing medical assessment.
- I am refusing medical treatment.
- I am refusing medical transportation.
- I have received medical assessment and treatment, but decline medical transportation.
- I am insisting on medical transport to a hospital other than EMS personnel recommend.

I understand that the EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand that I have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room may lack the staff, equipment, beds or resources to care for me promptly, and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by EMS personnel and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on the behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless all EMS providers and their officers, members, employees or other agents, and the base / modified base hospital, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the EMS providers or their personnel, or the base / modified base hospital or their personnel.

Other specific instructions to Patient: ____________________________________________________________

________________________________________

Signature of:  ☐ Patient  ☐ Parent  ☐ Legal Guardian  Print name of parent or legal guardian

________________________________________

Signature of Witness  Date

**PATIENT / GUARDIAN REFUSES TO SIGN:** I attest that the patient / guardian has refused care and/or transportation by the emergency medical services providers. The patient / guardian was informed of the risks of this refusal and refused to sign this form when asked by the EMS providers.

________________________________________  __________________________

Signature of Witness  Print Name of Witness

Updated 10/2010
Patient Initiated Release At Scene (RAS)
All criteria listed below must be met in order for patient to be Released at Scene

☐ Competent Adult, minor not requiring parental consent, or parent / guardian of a minor.
  Note: Minors determined to have only a minor injury or illness not requiring immediate treatment or transportation may be released to themselves after base / modified base consult (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation).
☐ Has a minor injury or illness.
☐ Has a clearly articulated plan (including reasonable and prudent transportation) for medical assessment and/or follow-up if necessary.
☐ EMS personnel concur with the appropriateness of scene release and the medical appropriateness of the follow-up plan.
☐ EMS personnel have attempted to contact the patient’s parent, legal representative, or designated caregiver prior to release if the patient is a minor being released to himself/herself or a responsible adult on scene.

Base / modified base contact shall be made by the highest medical authority on scene in close proximity to the patient is required prior to releasing the following classes of patients:

- Patients who have been released at scene within the previous 24 hours.
- Children 3 years of age or under.
- Patients age 4 – 17 years old without a responsible adult signature.

All patients who require base / modified base contact shall be assessed and offered treatment and transport by ALS / LALS personnel whenever possible. BLS personnel may only release these classes of patients if ALS / LALS personnel are not available (i.e. extremely extended ETA of ALS, 911 BLS ambulance provider without ALS response).

Patient Initiated Refusal of Service Against Medical Advice (AMA)

☐ Competent Adult or minor not requiring parental consent. Note: Parents / legal guardians for minors may sign AMA but must be present at scene.
☐ Has a significant medical concern or mechanism of injury, including all ALS / LALS chief complaints.
☐ EMS personnel do not concur with the refusal.

Base / modified base contact shall be made by the highest medical authority on scene in close proximity to the pt.

Note: In the event of communication failure, the method(s) of communication attempted and the reason for the communication failure must be documented on the PCR.

Involvement of law enforcement is required for the following patients:

- Any patient who presents with an ALOC and refuses care.
- Any patient refusing care who has attempted suicide or verbalizes suicide.
- A patient making a decision which is clearly irrational in the presence of a potentially life-threatening condition or has unstable vital signs and refuses care.
- If the patient is less than 18 y/o and a concern for child neglect or endangerment exists.
- A patient under a 5150 hold who refuses care.

If law enforcement refuses to assist in the facilitation of treatment and/or transport of a patient when indicated, EMS personnel should request that the officer on scene speak directly with the base / modified base MICN and/or physician.

Termination of EMS Personnel / Patient Relationship Checklist
Prior to the termination of the EMS Personnel / Patient relationship, all of the following will be evaluated. All areas identified on this checklist must be specifically documented on the Patient Care Report (PCR).

☐ Physical Examination performed including full set of vital signs.  ☐ Patient / guardian refused assessment.
☐ History of event and prior medical history, including medications obtained.  ☐ Patient / guardian refused assessment.
☐ Patient / guardian determined to be legally capable of refusing medical assessment, treatment, and transportation.
☐ Risks of refusal of medical assessment, treatment, and transportation explained to patient / guardian.
☐ Benefits of medical assessment, treatment, and transportation explained to patient / guardian.
☐ Patient / guardian clearly offered medical assessment, treatment, and transportation.
☐ Refusal of Care Form prepared, explained, signed and witnessed.
☐ Patient / guardian has a meaningful understanding of the risks and benefits involved in this healthcare decision.
☐ Patient / guardian advised to seek medical attention for complaint(s).
☐ Patient / guardian advised to call 911 if condition continues or worsens or if new symptoms develop.
☐ Base / modified base consultation was obtained if the patient meets criteria for AMA or RAS requiring base contact.

EMS PROVIDER SIGNATURE / PRINT NAME EMPOLYEE # / ID
____________________________________________________                  ____________________

Updated 10/2010
SIERRA SACRAMENTO VALLEY EMS AGENCY
TREATMENT PROTOCOL – MEDICAL EMERGENCY

RESPIRATORY
REFERENCE NO. R-3

SUBJECT: ACUTE RESPIRATORY DISTRESS

BLS

- ABC’s – limit physical exertion, reduce anxiety
- Assess respiratory status / High flow O₂ / Manage airway as appropriate
- Assess V/S
- Determine degree of illness
- CPAP when appropriate for moderate – severe distress
- History & Physical – fever, sputum production, medications, asthma, COPD, CHF, exposures, hypertension, tachycardia, JVD, edema

Asthma / COPD

Moderate – Severe Distress
- Cyanosis
- Accessory muscle use
- Inability to speak > 3 words
- Severe wheezing / SOB

Assist ventilation as needed

ALs

Albuterol
- 5 mg via HHN, mask or BVM
- If resp. distress persists, continuous Albuterol may be given during transport

IV/IO NS

Epinephrine 1:1,000
- For pt’s with acute asthma / bronchospasm only:
  - 0.01 mg/kg IM – thigh preferred (max = 0.5 mg)
Use cautiously in pt’s older than 35 yrs or with history of CAD or HTN

Mild Distress
- Mild wheezing / SOB
- Cough

ALS

Albuterol
- 2.5 – 5 mg via HHN
- May repeat if respiratory distress continues

IV NS
- Consider IV at appropriate rate

CHF / Pulmonary Edema

Moderate – Severe signs & symptoms

ALS

IV / IO NS TKO

BP x 2

ALs

* Nitroglycerin – Titrate SL based on 2nd BP as follows:
  - SBP > 200 – 1.2 mg SL
  - SBP 150 – 200 – 0.8 mg SL
  - SBP 100 – 150 – 0.4 mg SL
  - May repeat NTG q 5 minutes as above based on repeat BP
  - Do not delay NTG due to difficult IV / IO start
  - Do not administer if SBP < 100

If no improvement after 3 doses of NTG AND the patient is on a diuretic for heart failure:

Furosemide
- 80 mg IVP / IO over 1 – 2 min.

Mild signs & symptoms

ALS

IV NS TKO

* Nitroglycerin
  - 0.4 mg SL q 5 minutes
  - Do not administer if SBP < 100

* If the patient takes medication for erectile dysfunction or pulmonary HTN: should consult with base prior to starting nitroglycerin

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SUBJECT: INGESTIONS AND OVERDOSES

The MICN or Base / Modified Base physician may wish to contact Poison Control
• 1-800-876-4766 or 1-800-222-1222 / TTY: 1-800-972-3323

BASIC THERAPY

BLS
- ABC's
- Assess respiratory status / O₂
- Assess V/S
- Identify substance and time of ingestion. Bring sample in original container if possible.
- Assess History & Physical

ALS
- Cardiac Monitor
- Check Blood Glucose
- Treat specific ingestions according to specific treatment guidelines

Contact Base / Modified Base Hospital

Activated Charcoal
- 50gm PO
- Only give if patient is awake

Contraindications
- Acids / alkalais
- Corrosives
- Foreign body ingestions
- Prior administration of ipecac

For Specific Therapy See Pages 2 - 3
SUBJECT: INGESTIONS AND OVERDOSES

SPECIFIC THERAPY: INGESTIONS & OVERDOSES

**Narcotics**
- BLS & ALS Basic Therapy (page 1)
- Consider advanced airway if GCS ≤ 8
- IV / IO – NS @ TKO rate

**Nalaxone**
- Up to 2 mg SLOW IVP / IO
- May give 2 mg IM / IN if no IV / IO and / or SBP > 90
- Do not give Naloxone if advanced airway in place
- Use only for respiratory depression (not sleepiness), if RR < 12 or respiratory efforts are inadequate

**Contact Receiving Hospital**

**Tricyclic Antidepressants and Related Compounds**
- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS @ TKO rate

**Sodium Bicarbonate 1mEq/kg IVP / IO**
If any of the following are present:
- SBP < 90
- QRS > 0.12 seconds (3 small boxes)
- Seizures

**Calcium Channel Blockers**
- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS: 500ml fluid challenge if SBP < 90

**Calcium Chloride 10% 10ml SLOW IV / IO**
- Administer no faster than 1ml/minute
- ONLY if SBP < 90
- May repeat q 5 minutes – 4 total doses

**Beta Blockers**
- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS: 500ml fluid challenge if SBP < 90

**Atropine 1 mg IV / IO**
- If HR < 50 & SBP < 90 after fluid challenge
- May repeat q 5 minutes up to 3 mg max dose

**Glucagon 1 mg (1 unit) IV / IO**
- If HR < 50 & SBP < 90 systolic
- If no IV / IO or delay anticipated, may administer 2 mg IM / IN

**Epinephrine 1: 10,000 0.1 mg SLOW IV / IO**
- If SBP < 70
- Repeat until SBP > 90

**Contact Receiving Hospital**
**SPECIFIC THERAPY: INGESTIONS & OVERDOSES**

### Insulin or Oral Diabetic Agents
- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS @ TKO rate
- Check Blood Glucose

![Diagram of Insulin or Oral Diabetic Agents]

**Organophosphate or Carbamate Pesticides**
- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS @ TKO rate

- Atropine 2 mg IV / IO
  - If HR < 60
  - May repeat q 3 minutes
  - NO MAX DOSE

![Diagram of Organophosphate or Carbamate Pesticides]

**Hydrofluoric Acid (HF)**
- Oral ingestions require immediate treatment as Hydrofluoric Acid (HF) can cause fatal hypocalcemia
- QT interval prolongation is an early sign of hypocalcemia

- BLS & ALS Basic Therapy (page 1)
- IV / IO – NS @ TKO rate

- Calcium Chloride 10% 10ml SLOW IV / IO
  - Administer no faster than 1ml/minute
  - ONLY if signs of hypocalcemia

![Diagram of Hydrofluoric Acid (HF)]
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SUBJECT: SUSPECTED CVA / STROKE

BLS
- Assess ABC’s
- Assess respiratory status / high flow O₂
- Assess V/S
- Assess History & Physical
- Perform Cincinnati Prehospital Stroke Scale assessment
- Determine time of symptoms onset and when pt last seen normal

ALS
- Cardiac Monitor
- Pulse Ox
- Check Blood Glucose
- Consider Advanced Airway if GCS ≤ 8
- IV / IO TKO

Suspect CVA if:
- New onset symptoms with abnormal stroke scale
- Unexplained new altered LOC (GCS < 14) without response to Glucose, Glucagon or Narcan

Cincinnati Prehospital Stroke Scale
New Onset Symptoms

Facial Droop
(Have pt show teeth or smile)
Normal = Both sides of face move equally well.
Abnormal = One side of face does not move as well as the other side.

Arm Drift
(Pt closes eyes & extends both arms straight out for 10 seconds)
Normal = Both arms move the same or both arms do not move at all.
Abnormal = One arm does not move or one arm drifts down compared to the other.

Speech
(Have pt say: “You can’t teach an old dog new tricks”)
Normal = Pt uses correct words with no slurring.
Abnormal = Pt slurs words, uses the wrong words or is unable to speak

Interpretation: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%

Stroke Symptoms ≤ 2.5 hours
YES

NO
Contact Closest Base / Modified Base Hospital

≤ 30 minutes of a Stroke Receiving Center
YES

NO
Transport to a Stroke Receiving Center
Advising the Stroke Receiving Center of a “Stroke Alert”

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TREATMENT PROTOCOL – MEDICAL EMERGENCY
ENVIRONMENTAL
REFERENCE NO. E-2

SUBJECT: COLD STRESS EMERGENCIES : HYPOTHERMIA

BLS

- Assess ABC’s – establish and secure airway. Use adjuncts to prevent aspiration or if ventilations are inadequate (4 – 6 breaths per minute MAY be adequate)
- Consider – spinal precautions
- O₂ – at appropriate flow rate: should be humidified & warmed if possible
- Temperature – take pt’s temperature if thermometer is available
- Pulse – assess for 60 seconds or greater (if necessary)
- Warm Environment – extreme care & gentleness must be exercised when moving patient. Minimize physical movement of patient. Remove wet clothing and cover patient with warmed blankets &/or clothing
- AED – if necessary

ALS

- Cardiac Monitor

V Tach or V Fib ?

YES

Start CPR
Give 1 shock
- Manual biphasic: device specific (typically 120 – 200 J). If unknown, use 200 J.
- AED: device specific.
- Monophasic: 360 J
Resume CPR immediately

NO

- IV / IO NS – 500 ml fluid bolus (warm fluid if available)
- Check Blood Glucose

Results ≤ 60 mg/dl ?

YES

Dextrose 50%
- 50 ml (25gm) IV / IO
If no IV / IO or delay anticipated:
- Glucagon
  - 1 unit (1 mg) IM / IN

NO

Frostbite ?

YES

Go to Frostbite Protocol E-3

NO

Contact Receiving Hospital

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Page 1 of 1

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TREATMENT PROTOCOL – MEDICAL EMERGENCY

ENVIRONMENTAL REFERENCE NO. E-7

SUBJECT: HAZARDOUS MATERIAL EXPOSURE

Haz Mat incidents require special attention and frequently the need for specially trained personnel. Refer to policy # 836 Hazardous Material Incidents.

Important Caveats For Medical Responders:

- Do not enter a contaminated area unless properly protected.
- Personal Protective Equipment (PPE) including SCBAs shall not be utilized by untrained personnel.
- Do not transport a contaminated patient without base/modified base approval until the patient has been thoroughly decontaminated.
- Do not delay the treatment or transportation of Immediate patients who are contaminated with radioactive material (see page 3).
- If transporting personnel become contaminated, they shall immediately undergo decontamination.
- Early base/modified base contact, and CHEMPACK activation when appropriate, will maximize assistance from necessary resources.
- Refer to Hazardous Materials Medical Management Reference as appropriate.

Information that must be obtained by EMS personnel on every Haz Mat incident:

- Number of patients.
- Material involved or DOT 4-digit placard #.
- Route(s) of exposure for each patient.
- Signs & Symptoms for each patient.
- Decontamination procedure completed for each patient.
- Procedure utilized to determine effectiveness of decontamination procedure.
- Risk of secondary exposure to rescuers.
- PPE required to transport patient.

For Specific Therapy See Pages 2 - 3
SIERRA SACRAMENTO VALLEY EMS AGENCY
TREATMENT PROTOCOL – MEDICAL EMERGENCY

SUBJECT: HAZARDOUS MATERIAL EXPOSURE

**BLS**
- ABC’s – establish and secure airway, with adjuncts as appropriate and necessary
- O₂ at appropriate flow rate
- If trauma suspected, use full spinal immobilization when indicated
- Contact base/modified base hospital for assistance in determining a decontamination and treatment plan if necessary
- After patient is fully decontaminated, cover with blankets and/or sheets as appropriate for medical and weather conditions
- If eye exposure occurs, irrigate each exposed eye with NS – ensure contact lenses are removed

**ALS**
- Cardiac Monitor
- IV/IO – NS in non-burned/non-contaminated extremity

**CHEMICAL BURNS**
IF isolated burn without inhalation is documented and ALL of the following are present:
- SBP > 100
- No allergy to Morphine
- Patient in moderate - severe pain

Morphine Sulfate
- 2 mg increments slow IVP / IO (max 2mg/min)
- Titrate to tolerable pain level
- Discontinue Morphine if SBP < 100

**HYDROFLUORIC ACID (HF)**
- Calcium Chloride 10%
  - 10 mL slow IVP / IO
  - May repeat q 5 minutes

For HF burns that are isolated to the hand(s), finger(s), or toe (s):
- Calcium Chloride 10%
  - Pour contents of one ampule into a sterile glove and immerse affected area into solution
  - If Calcium Gluconate gel has been applied, do not remove. No further treatment is necessary

Skin exposure to HF with a concentration > 20% can cause fatal hypocalcemia and should be treated. Provide continuous EKG monitoring to look for QT-interval prolongation which is an early sign of hypocalcemia

**ORGANOPHOSPHATE OR CARBAMATE**
- Atropine
  - 2 mg IV / IO if HR < 60
  - May repeat q 3 minutes to HR > 80
  - No maximum dose

Refer to Nerve Agent Treatment Protocol E-8 if additional treatment is necessary

NOTE: Precautions must be taken to prevent direct contact with secretions of the patient who has ingested organophosphates or carbamate pesticides
RADIATION EMERGENCIES

- Patient care always takes priority over radiological concerns. Addressing contamination issues should not delay treatment of life-threatening injuries.
- Viable patients are a high priority. Therefore, rapidly extricate, treat and transport those patients who are most critical and likely to survive.
- It is highly unlikely that the levels of radioactivity associated with a contaminated patient would pose a significant health risk to care providers.
- Body Substance Isolation Clothing (gloves, gowns, N-95 masks, protective eyewear, shoe protectors, and head cap) are recommended, including 2-3 pair of disposable gloves.
- Due to fetal sensitivity to radiation, assign pregnant staff to other duties.

AMBULANCE PREPARATION

If time permits, consider the following:
- Avoid using internal and external compartments; work out of mobile kits as much as possible.
- Close all internal compartments prior to loading patient.
- Cover radio communication microphones with a rubber glove.
- Cover floor of ambulance with disposable papers or pads.

patients

- If oxygen is warranted for patient treatment use a non re-breather mask, if patient will tolerate it. Additionally, the mask provides protection from inadvertent respiratory contamination hazards. An N95 mask is appropriate to protect patient from inadvertent respiratory contamination hazards when oxygen is not indicated.
- Frequent glove changes will reduce the spread of contamination, and should be considered prior to handling patient, and patient care adjuncts.
- All medical procedures should be utilized to save an immediate patient. If it is medically necessary to intubate a patient that is contaminated, then do so.
- Change gloves prior to intubation.
- Maintain endotracheal tube sterility if possible.

Pt's with limited / no field decontamination

- Initiate ALS care as necessary.
- Keep patient wrapped (cocoon style) as much as possible to minimize the potential for contamination spread.
- Only expose areas to assess and treat.
- If necessary, cut and remove the patient's clothing away from the body being careful to avoid contamination to the unexposed skin.
- Properly contain all removed clothing by placing it in a sealable bag.
- Continue to reassess and monitor vitals while en route to the appropriate receiving facility.
- Contact with patient may result in transfer of contamination; change gloves as necessary.

Pt's with field decontamination

- Patients with non life-threatening injuries should have field decontamination prior to removal from the hot zone.
- Patient's condition permits a more thorough radiological survey prior to continued care.
- Conduct a head to toe assessment as the patient's injuries warrant.
- If patient's clothing has not been removed during decontamination procedures, keep patient wrapped (cocoon style) as much as possible.
- Expose patient's injuries for assessing and treating only.
- Contact with patient may result in transfer of contamination; change gloves as necessary.
SIERRA SACRAMENTO VALLEY EMS AGENCY
TREATMENT PROTOCOL – MEDICAL EMERGENCY

TRAVMA
REFERENCE NO. T-6

SUBJECT: ISOLATED EXTREMITY INJURY – INCLUDING HIP OR SHOULDER INJURIES

BLS
- ABC’s
- Assess respiratory status / O₂
- Assess V/S
- Splint injury if necessary

Uncontrolled extremity bleeding?

Does pt meet Trauma Triage Criteria?

ALAS

Are All of the following present?
- Pain scale documented & patient in pain
- RR > 12
- SBP > 100 systolic
- GCS = 15 or baseline mental status

NO

Reassess as needed

YES

Go to General Trauma Mgmt. Protocol T-1

Are All of the following present?
- Pain scale documented & patient in pain
- RR > 12
- SBP > 100 systolic
- GCS = 15 or baseline mental status

NO

Reassess as needed

YES

Morphine Sulfate
- 2 – 5 mg IM / SQ
- May repeat x 1 (max dose 10 mg)

IV / IO Access?

YES

Morphine Sulfate
- 2 – 5 mg increments SLOW IVP / IO
- Titrate to pain

Adequate pain relief?

YES

Reassess as needed

NO

Morphine Sulfate
- 2 – 5 mg increments SLOW IVP / IO
- Titrate to pain

* Use caution when administering both morphine and midazolam to patients

Morphine Sulfate
- 2 – 5 mg increments SLOW IVP / IO
- Titrate to pain

Midazolam - If necessary
- 0.1 mg/kg Slow IVP / IO (max total dose 4 mg)

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TREATMENT PROTOCOL – MEDICAL EMERGENCY

TRAUMA
REFERENCE NO. T-8

SUBJECT: UNCONTROLLED EXTREMITY BLEEDING

BLS

- ABC's
- Assess respiratory status / O2
- Assess V/S
- Attempt to control bleeding with direct pressure

Uncontrolled extremity bleeding?

Does pt meet Trauma Triage Criteria?

NO

YES

Apply approved commercial tourniquet device to bleeding limb(s) on proximal segment

Reassess as needed

Transport ≥ 30 min. expected?

NO

YES

Go to General Trauma Mgmt. Protocol T-1

Amputation or Near-Amputation?

NO

YES

Apply pressure dressing and loosen tourniquet (leaving it in place)

Significant bleeding from site?

NO

YES

Tighten tourniquet & leave in place

Go to General Trauma Mgmt. Protocol T-1

Leave tourniquet in place

Go to General Trauma Mgmt. Protocol T-1

Reassess as needed

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TREATMENT PROTOCOL – MEDICAL EMERGENCY

PEDIATRIC
REFERENCE NO. P-2

SUBJECT: NEONATAL RESUSCITATION – INFANTS ≤ 28 DAYS OLD

Approximate Time

30 SEC

A

B

C

D

• BIRTH

• Term gestation?
• Clear amniotic fluid?
• Breathing or crying?
• Good muscle tone?

YES

NO

• Provide warmth
• Position; Clear airway * (as necessary)
• Dry, stimulate, reposition

Routine Care
• Provide Warmth
• Clear airway if needed
• Dry
• Assess Color

Breathing, HR > 100 and Pink

Observational Care

Evaluate respirations, heart rate, and color

Breathing, HR > 100 but Cyanotic

100% 02 via mask

Persistent Cyanosis

• Positive-pressure ventilation *
  with BVM 40-60/min with 100% 02

HR < 60

HR > 60

Effective Ventilation
HR > 100 & Pink

Post Resuscitation Care

HR < 60

• CPR – Rate 120 / min – compression:ventilation ratio 3:1
• Intubate * if necessary
• IV / IO NS TKO

Epinephrine
• IV / IO: 0.01 – 0.03 mg/kg 1:10,000 (0.1 – 0.3 mL/kg)
• ET: 0.1 mg/kg 1:1,000 (0.1 mL/kg)

• Endotracheal Intubation may be considered at several steps, perform only if BVM ventilation is unsuccessful or impossible.
• See note on page 2 for meconium aspiration

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Page 1 of 2
Clearing the airway of meconium:

If the amniotic fluid contains meconium and the infant has absent or depressed respirations, decreased muscle tone, or a heart rate < 100 bpm; do not stimulate or ventilate the infant until meconium has been cleared from the airway as follows:

- **Suction capability ≤ 80 mm Hg:**
  
  Perform direct laryngoscopy immediately after birth for suctioning of the hypo pharynx and intubation/suction of the trachea. Accomplish tracheal suctioning by applying suction directly to the endotracheal tube (utilizing a meconium aspirator), as it is withdrawn from the airway. Repeat intubation and suctioning until little additional meconium is recovered or until the heart rate indicates that resuscitation must proceed without delay.

- **Suction capability > 80 mm Hg**

  **Do not use an endotracheal tube to suction the trachea.** Use a bulb syringe and, if necessary, a suction catheter to thoroughly suction meconium from the nose, mouth and oropharynx. A laryngoscope blade may be inserted to assist in visualization of the oropharynx during suction with the catheter. Intubation may be necessary for respiratory depression.

Ventilate the infant at 40 to 60 breaths per minute (visualizing rise in chest). Use a neonatal resuscitator bag with oxygen reservoir apparatus.
SUBJECT: RESPIRATORY DISTRESS – WHEEZING (LOWER AIRWAY: ASTHMA)

- Wheezing – A high pitched, whistling sound, during expiration, characterizing disease, obstruction or spasm of the lower airways. It may be caused by asthma or bronchiolitis.
- Obtain History – Foreign body aspiration, fever, drooling, sore throat, sputum production, onset, duration.
- Do not attempt to visualize the throat or insert anything into the mouth if epiglottitis suspected.
- Consider respiratory failure when a child has a history of increased work of breathing and is presenting with an altered LOC and a slow or normal respiratory rate without retractions.

BLS

- Routine medical care
- Position of comfort
- High flow $O_2$ by blow-by or mask
- Keep patient calm – allow parent to hold the child and/or $O_2$ mask, if the presence of the parent calms the child
- Consider BVM/assist respirations early for altered LOC or severe distress

ALS

- Cardiac monitor
- Pulse oximetry

Albuterol
- 5 mg via HHN, mask or BVM
- May repeat x 1 dose

If response to Albuterol inadequate:

Epinephrine
- 1:1,000 – 0.01 mg / kg IM – thigh preferred (max = 0.3 mg)

- Intubate – as needed for severe distress if BVM unsuccessful or impossible

- IV / IO NS

Contact Receiving Hospital

SIGNES OF RESPIRATORY DISTRESS

MILD RESPIRATORY DISTRESS
- Mild Wheezing
- SOB
- Cough

MODERATE – SEVERE RESPIRATORY DISTRESS
- Cyanosis
- Accessory muscle use
- Inability to speak > 2 words
- Severe Wheezing / SOB
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**MILD**
- Acute onset
- Cutaneous reactions, e.g. hives, pruritis, flushing, rash, or angioedema **NOT involving the airway**

- **O₂** – Blow by or Non-rebreather mask
- Position of comfort

**Diphenhydramine**
- 1 mg/kg PO, IM or IV (max = 50 mg)

**MODERATE**
- Rapid onset
- Wheezing, mild bronchospasm
- Respiratory distress, retractions
- Itching, rash, hives
- Nausea, weakness, anxiety
- Normotensive for age, tachycardia, SaO₂ > 95%

- **O₂** – Blow by or Non-rebreather mask
- Position of comfort

**Epinephrine 1:1,000**
- 0.01 mg/kg IM - thigh preferred (max = 0.3 mg)

**Diphenhydramine**
- 1 mg/kg IM or IV (max = 50 mg)

**For Wheezing / Bronchospasm**
**Albuterol**
- 5 mg in 6 ml NS via HHN, mask or BVM

**ANAPHYLAXIS**
- Abnormal appearance (agitation, restlessness, somnolence)
- Altered Mental Status
- Signs of diminished perfusion (weak brachial pulse, delayed cap refill, pale or cool skin)
- Respiratory distress - severe bronchospasm
- Stridor
- Bradycardia
- **SaO₂ < 95% on RA**

- **O₂** – High flow by mask, consider BVM early for ALOC or respiratory distress

**Epinephrine 1:1,000**
- 0.01 mg/kg IM - thigh preferred (max = 0.3 mg)

**IV/IO access**
- Bolus 20 ml/kg NS
- As quickly as possible

**For Wheezing / Bronchospasm**
**Albuterol**
- 5 mg via HHN, mask or BVM

**Epinephrine 1:1,000 – Only If unable to give IV / IO**
- 0.1 mg/kg ET (Max single dose = 2 mg)

**Epinephrine 1:10,000**
- 0.01 mg/kg IV/IO (Max single dose = 0.1 mg)

**Diphenhydramine**
- 1 mg/kg IM or IV/IO (max dose: 50 mg)
SIERRA SACRAMENTO VALLEY EMS AGENCY
TREATMENT PROTOCOL – MEDICAL EMERGENCY

PEDIATRIC
REFERENCE NO. P-24

SUBJECT: ALTERED LEVEL OF CONSCIOUSNESS

- Clinical setting and/or medical history may dictate Dextrose or Naloxone as the initial medication
- Note: Glucose paste or Glucose solution, sugared soft drinks, orange juice or other oral glucose may be administered if the patient is: 1) able to maintain their airway; 2) able to follow commands; and, 3) able to self-administer the oral glucose
- Consult with base physician if the Blood Glucose reading is ≥ 60 mg/dl but hypoglycemia is suspected

BLS

- Assess & support ABC’s as needed / high flow O₂ by mask
- Consider BVM early for altered LOC or respiratory distress

ALS

- Monitor
- Pulse oximetry
- IV / IO NS
- Check Blood Glucose

Inadequate or depressed respirations?

Naloxone
- 0.1 mg/kg IV / IO, IM or IN (max dose 2 mg)
- If no improvement, consider repeat dose x 2 (total 3 doses) q 2-3 minutes
* Naloxone is to be given for inadequate respiratory status only, not for sleepiness

Dextrose 12.5%
- 2 mL/kg IV / IO

Results < 60 mg/dl?

Neonate ≤ 28 days old?

Dextrose 25%
- 2 mL/kg (0.5 gm/kg) IV / IO (max dose 25 gm)
If no IV / IO or delay anticipated

Glucagon
- 0.5 mg IM / IN (up to age 14)

Adequate response?

Adequate response?

Consider additional Doses of Naloxone

Contact Receiving Hospital

If ALTE go to ALTE protocol P-3

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S-SV EMS Regional Executive Director

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SUBJECT: ISOLATED EXTREMITY INJURY – INCLUDING HIP OR SHOULDER INJURIES

BLS
- ABC’s
- Assess respiratory status / O₂
- Assess V/S
- Splint injury if necessary

Does pt meet Trauma Triage Criteria?

Uncontrolled extremity bleeding?

ALS

Are ALL of the following present?
- Pain scale documented & pt has moderate – severe pain
- RR > 12
- SBP > age appropriate
- GCS = 15 & no evidence of head injury
- AGE ≥ 4 YEARS OLD

YES

NO

Go to General Pediatric Protocol P-1

NO

YES

Contact Base / Modified Base Hospital if additional pain relief required

Morphine Sulfate
- 0.2 mg/kg SQ / IM (max 10 mg)
- May repeat x 2 (max total = 30mg)
- Titrate to tolerable pain level

Reassess as needed

Morphine Sulfate
- 0.1 mg/kg SLOW IVP / IO (max 5 mg)
- May repeat x 2 (max total dose 15 mg)
- Titrate to tolerable pain level

IV / IO Access?

YES

NO

Reassess as needed

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SUBJECT: UNCONTROLLED EXTREMITY BLEEDING

BLS

- ABC’s
- Assess respiratory status / O₂
- Assess V/S
- Attempt to control bleeding with direct pressure

Uncontrolled extremity bleeding?

YES

- Apply approved commercial tourniquet device to bleeding limb(s) on proximal segment

NO

Does pt meet Trauma Triage Criteria?

YES

Go to General Pediatric Protocol P-1

NO

Reassess as needed

Transport ≥ 30 min, expected?

YES

Reassess tourniquet for removal

NO

Amputation or Near-Amputation?

YES

Leave tourniquet in place

NO

- Apply pressure dressing and loosen tourniquet (leaving it in place)

Significant bleeding from site?

YES

Tighten tourniquet & leave in place

NO

Go to General Pediatric Protocol P-1

NO

Leaves tourniquet in place

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SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

PURPOSE:

To establish a mechanism for an individual to be certified as an EMT in the State of California.

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 LEMSA certifying entity.

DEFINITIONS:

A. Emergency Medical Technician (EMT) – means a person who has successfully completed an EMT course which meets the requirements of the California Code of Regulations, Title 22, Division 9, Chapter 2, has passed all required tests, and who has been certified by an EMT certifying entity

B. EMT Certifying Entity – for the purposes of this policy means the S-SV EMS Agency Medical Director.

PROCEDURE

I. INITIAL CERTIFICATION:

A. In order to be eligible for initial certification an individual shall:
REFERENCE NO. 901

SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

1. Have a valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100066 of the California Code of Regulations, Title 22, Division 9, Chapter 2; or,

2. Have documentation of successful completion of an approved out-of-state initial EMT training course, within the last two (2) years which meets the requirements of the California Code of Regulations, Title 22, Division 9, Chapter 2.

3. Apply for certification within two (2) years of the date of course completion.

4. Pass the National Registry of Emergency Medical Technicians EMT-Basic skills examination. 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.

5. Pass the National Registry of Emergency Medical Technicians EMT-Basic Written Examination. Examination results will be valid for application purposes two (2) years from the date of examination.

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

7. Complete the following criminal history background check requirements:

   a. Submit a completed request for “Live Scan Applicant Submission Form, BCII 8016 (Rev 06/09),” to the California DOJ for a state and federal Criminal Offender Record Information (CORI) search in accordance with the provisions of Section 11105 (p) (1) of the California Penal Code; and,

   b. The CORI request shall include a subsequent arrest notification report in accordance with the provisions of Section 11105.2 of the California Penal Code; and,

   c. The EMT applicant will designate that both the state and federal CORI search results and the subsequent arrest notification reports shall be reported to the S-SV EMS Agency and the California EMS Authority.

8. 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.”
SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

9. Disclose any certification or licensure action:
   a. Against an EMT, Advanced EMT, EMT-II certificate or a Paramedic license or any denial of certification by a LEMSA including active investigations; or,
   b. In the case of Paramedic, licensure denial by the Authority, including any active investigations.
   c. Against any EMS-related certification or license of another state or other issuing entity, including active investigations.
   d. Against any health related license.

10. Pay the established fees.

B. In order for an individual, whose California Advanced EMT certificate, EMT-II certification or Paramedic License has lapsed, to be eligible for certification as an EMT the individual shall:

1. For a lapse of less than six (6) months, the individual shall comply with the requirements contained in sub-section A, item 7 of this ‘Initial Certification’ section of the policy as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Recertification’ section of this policy.

2. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall comply with the requirements contained in sub-section A, item 7 of this ‘Initial Certification’ section of the policy as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Recertification’ section of this policy and complete an additional twelve (12) hours of CE for a total of thirty-six (36) hours of training.

3. For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall comply with the requirements contained in sub-section A, item 7 of this ‘Initial Certification’ section of the policy as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Maintaining Certification and Recertification’ section of this policy and complete an additional twenty-four (24) hours of CE for a total of forty-eight (48) hours of training. The individual shall also pass the written and skills certification exams as specified in sub-section A, items 4 and 5 of this ‘Initial Certification’ section of the policy.

4. For a lapse of twenty-four (24) months or more the individual shall complete an entire EMT course and comply with all requirements contained in sub-section A of this ‘Initial Certification’ section of the policy.
C. An individual currently licensed in California as a Paramedic or currently certified in California as an Advanced EMT or EMT-II is deemed to be certified as an EMT, except when the paramedic license or the Advanced EMT or EMT-II certification is under suspension, with no further testing required. In the case of a paramedic license, or Advanced EMT or EMT-II certification under suspension, the individual shall apply to the S-SV EMT Agency for EMT certification.

D. An individual who meets one of the following criteria shall be eligible for initial certification upon fulfilling the requirements contained in sub-section A, items 6, 7, 8, 9 and 10 of this ‘Initial Certification’ section of the policy:

1. Possess a current and valid National Registry EMT-Basic registration certificate. Possession of a current and valid National Registry EMT-Basic registration certificate alone, does not meet California EMT certification requirements.

2. Possess a current and valid out-of-state or National Registry EMT-Intermediate or Paramedic certificate. Possession of a current and valid National Registry Intermediate or Paramedic certificate alone, does not meet California EMT certification requirements.

3. Possess a current and valid California Advanced EMT or EMT-II certification or a current and valid California Paramedic license.

E. An individual who possesses a current and valid out-of-state EMT certificate, shall be eligible for certification upon fulfilling the requirements contained in sub-section A, items 4, 5, 6, 7, 8, 9 and 10 of this ‘Initial Certification’ section of the policy.

F. The EMT certifying entity shall issue a wallet-sized certificate card to eligible individuals, using the single California EMS Authority approved wallet-sized certificate card format. The wallet-sized certificate card shall contain the following:

1. Name of the individual certified.

2. Date the certificate was issued.

3. Date of expiration.


5. Registry number, generated by the registry.

G. All California issued EMT wallet-sized certificate cards shall be printed by the EMT certifying entity using the central registry criteria, pursuant to California Code of Regulations, Title 22, Division 9, Chapter 10, Section 100344.
SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

H. The effective date of certification, as used in this policy, shall be the date the individual applicant has applied for and satisfactorily completes all certification requirements. Certification as an EMT shall be valid for a maximum of two (2) years from the date that the individual passes the National Registry EMT-Basic certifying exam, except in the following cases:

1. A person who possesses a current and valid out-of-state EMT-Intermediate or Paramedic certification, the expiration date shall be the same expiration date as stated on the out-of-state certification but in no case shall exceed two (2) years from the effective date of EMT wallet-sized certificate card issued by a California EMT certifying entity.

2. A person who possesses a valid National Registry issued EMT-Basic, EMT-Intermediate or Paramedic certification, the expiration date shall be two (2) years from the date of passing the National Registry examination whichever is soonest, but in no case shall the expiration date of certification exceed two (2) years from the effective date.

3. That an individual currently licensed in California as a Paramedic, as listed in sub-section C of this ‘Initial Certification’ section of the policy, shall have an EMT expiration date that is the same as the current Paramedic license.

I. The EMT shall be responsible for notifying the EMT certifying entity of her/his proper and current mailing address and shall notify the EMT 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.

J. The EMT certifying entity shall issue, within forty-five (45) calendar days of receipt of a complete application as specified in the ‘Initial Certification’ section of the policy, a wallet sized EMT certificate card to eligible individuals who apply for an EMT certificate and successfully complete the EMT certification requirements.

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

II. 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 requirements contained in S-SV EMS ‘EMT / AEMT Continuing Education Requirement Overview’ Policy, Reference No. 1001-A; or,
3. Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program.

4. 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 or EMT-II to satisfy the CE requirement for EMT recertification as specified in this section.

5. Complete the criminal history background check listed in sub-section A, item 7 of the ‘Initial Certification’ section of this policy, if not previously completed.

6. Complete an application and other processes as specified in sub-section A, items 8 and 10 of the ‘Initial Certification’ section of this policy.

7. Submit a completed skills competency verification form, EMSA-SCV (S-SV EMS Reference No. 901-A).

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, EMT-II, Paramedic, Registered Nurse, Physician’s Assistant, or Physician and who shall be designated by an EMS approved training program (EMT 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. The skills requiring verification of competency are:

a. Patient examination, trauma patient
b. Patient examination, medical patient
c. Airway emergencies
d. Breathing emergencies
e. CPR and AED
f. Circulation emergencies
g. Neurological emergencies
h. Soft tissue injuries
i. Musculoskeletal injuries
j. Obstetrical emergencies

B. If the EMT recertification requirements are met within six (6) months prior to the expiration date, the EMT certifying entity shall make the effective date of certification the date immediately following the expiration date of the current certificate. The certification expiration date will be the final day of the final month of the two (2) year period.
C. 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 certification the date the individual satisfactorily completes all certification requirements and has applied for certification. The certification expiration date shall not exceed two (2) years and shall be the final day of the final month of the two (2) year period.

D. An Individual who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose California EMT certificate expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, may be given an extension of the expiration date of the individual’s EMT certificate for up to six (6) months from the date of the individual’s deactivation/release from active duty in order to meet the renewal requirements for the individual’s EMT certificate upon compliance with the following provisions:

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

2. If there is no lapse in certification, meet all the requirements listed in sub-section A of this ‘Recertification’ section of the policy. If there is a lapse meet the requirements listed in the ‘Recertification After Lapse in Certification’ section of this policy.

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

For an individual whose active duty required him/her to use his/her EMT skills, credit may be given for documented training that meets the requirements contained in S-SV EMS ‘EMT / AEMT Continuing Education Requirement Overview’ Policy, Reference No. 1001-A while the individual was on active duty. The documentation shall include verification from the individual’s Commanding Officer attesting to the classes attended.

E. The EMT certifying entity shall issue a wallet-sized certificate card to eligible individuals. The certificate shall contain the information listed in sub-section F of the ‘Initial Certification’ section of this policy.

III. RECERTIFICATION AFTER LAPSE IN CERTIFICATION

A. In order to be eligible for recertification for an individual whose California EMT Certification has lapsed, the following requirements shall apply:
1. For a lapse of less than six (6) months, the individual shall comply with the requirements listed in sub-section A, item 7 of the ‘Initial Certification’ section of this policy, as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Recertification’ section of this policy.

2. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall comply with the requirements listed in sub-section A, item 7 of the ‘Initial Certification’ section of this policy, as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Recertification’ section of this policy, and complete an additional twelve hours of continuing education for a total of thirty-six (36) hours of training.

3. For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall comply with the requirements listed in sub-section A, item 7 of the ‘Initial Certification’ section of this policy, as well as sub-section A, items 2 or 3, 6 and 7 of the ‘Recertification’ section of this policy, and complete an additional twenty-four (24) hours of continuing education for a total of forty-eight (48) hours of training. The individual shall also pass the written and skills certification exams as specified in sub-section A, items 4 and 5 of the ‘Initial Certification’ section of this policy.

4. For a lapse of greater than twenty-four (24) months, the individual shall complete an entire EMT course and comply with all of the requirements listed in sub-section A of the ‘Initial Certification’ section of this policy.

B. Individuals who are a member of the reserves and are deployed for active duty with a branch of the Armed Forces of the United States, whose EMT certificate expired during the time the individuals are on active duty may be given an extension of the expiration date of the individuals EMT certificate for up to six (6) months from the date of the individuals deactivation/release from active duty in order to meet the renewal requirements of the individuals EMT certificate upon compliance with the provisions listed in sub-section D of the ‘Recertification’ section of this policy, and subsection A of this ‘Recertification After Lapse in Certification’ section of the policy.

C. The effective date of recertification shall be the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date shall be the final day of the final month of the two (2) year period, except for those individuals who are required to pass the written and skills certifying examinations, the expiration date shall be the last day of the final month of the two (2) year period following the date of passing the certifying written examination.

D. The EMT certifying entity shall issue a wallet-sized certificate card to eligible individuals who apply for recertification and successfully complete the recertification requirements. The certificate shall contain the information listed in subsection F of the ‘Initial Certification’ section of this policy.
SUBJECT: EMT CERTIFICATION AND RECERTIFICATION

CROSS REFERENCES:

Policy and Procedure Manual

EMT / AEMT Incident Investigations, Determination of Action, Notification and Administrative Hearing Process, Reference No. 903
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SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

PURPOSE:

To establish a mechanism for obtaining accreditation to practice as a paramedic in the S-SV EMS region, and to outline requirements for maintaining S-SV accreditation.

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.

POLICY:

A. In order to be eligible for accreditation, an individual shall:

1. Possess a valid Paramedic License issued in the State of California.

2. Complete an S-SV Paramedic Accreditation application.

3. Provide written proof of affiliation in the S-SV EMS region with an approved ALS service provider.

4. Pay the accreditation fee.

5. Provide a copy of California Driver’s License or government issued photo identification card.

6. Once the above steps are completed, attend an S-SV EMS approved orientation of the S-SV EMS system.

7. Successfully complete and demonstrate competency in optional S-SV Paramedic Scope of Practice procedures/medications. Once successfully tested in any of these procedures/medications in any jurisdiction in California, no further testing shall be required if the testing agency or jurisdiction provides documentation.

8. Successfully complete a supervised pre-accreditation field evaluation consisting of up to 10 ALS contacts.
a. This requirement shall be waived by providing documentation of five (5) ALS contacts in the S-SV region during the paramedic education program field internship.

b. This requirement shall be waived 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.

9. Pass an S-SV examination on S-SV policy/procedure and protocols with a minimum score of 80%. If the examination is failed twice, the orientation shall be repeated prior to re-testing.

10. All of the above requirements shall be met within 60 days of completion of the S-SV orientation.

11. Upon completion of all the above requirements, the individual will be issued an S-SV Paramedic Accreditation Card with effective and expiration dates. The S-SV Paramedic Accreditation Card will have the same expiration date as the individual’s current California State Paramedic license.

B. Requirements for Maintaining S-SV Paramedic Accreditation:

To maintain continuous accreditation, a paramedic shall:

1. Complete and submit an S-SV Paramedic Accreditation application.

2. Maintain and provide proof of continuous paramedic licensure in the State of California.

3. Maintain employment as a paramedic in the S-SV region with an approved ALS service provider.

4. Provide proof of PALS or PEPP recognition.

   PALS/PEPP recognition will not be required at the time of initial accreditation in the S-SV region. PALS/PEPP recognition will be required at the time of paramedic re-accreditation.

5. Completion of S-SV EMS Agency mandated education, as required. This education includes, but is not limited to, policies, procedures, skills, medications and/or devices/equipment.

6. The ALS service provider will provide orientation to all Paramedic personnel for all new and/or revised policies/protocols and/or procedures.

   a. The ALS service provider shall be responsible for ensuring that all field employees are kept current on local policies and procedures. This
includes part-time employees that may work shifts within the S-SV EMS region on an infrequent basis.

b. The ALS service provider shall be responsible for ensuring that all S-SV mandatory education requirements are met/completed by all ALS personnel.

7. Upon submission of a completed application and copies of the current state license and PALS / PEPP recognition, the individual will be issued an S-SV Paramedic Accreditation Card with effective and expiration dates. The S-SV Paramedic Accreditation Card will have the same expiration date as the individual’s current California State Paramedic license.

C. Lapse in maintaining S-SV Paramedic Accreditation Requirements:

A lapse in maintenance of S-SV requirements for paramedic accreditation shall require the following in order to be eligible for S-SV Paramedic Accreditation:

1. A lapse of less than one year:
   a. Complete and submit an S-SV Paramedic Accreditation application form.

2. A lapse of more than one year but less than two years:
   a. Complete and submit an S-SV Paramedic Accreditation application form.
   b. Provide the S-SV EMS Agency with written documentation of completion of orientation/training by the employing ALS service provider to all S-SV EMS Agency protocol updates during the lapse of accreditation.

3. A lapse of more than two years:
   a. All requirements for initial accreditation, as outlined in Section A of this policy, shall be met.

D. ALS Service Provider Agency Responsibilities:

If there is a change in the employment status of an S-SV accredited paramedic employee; the ALS service provider shall immediately submit a completed “S-SV Paramedic Employee Status Report”, Reference No. 913-A, to the S-SV EMS Agency.

CROSS REFERENCES:

Policy and Procedure Manual

Paramedic Scope of Practice, Reference No. 803.
S-SV EMS AGENCY
PARAMEDIC EMPLOYEE
STATUS REPORT

Paramedic________________________________________________________

State License # ____________________  Expiration Date____________________

The following employee status change has occurred at:

ALS Service Provider _____________________________________________

☐ Has been hired as a Paramedic and will be working in the S-SV EMS Region.
   Effective employment date: __________________________

☐ Has been hired as a Paramedic and will be working in the S-SV EMS Region, pending completion of the S-SV Accreditation process.

☐ Is no longer employed as a Paramedic.

☐ Has failed to maintain:
   ☐ California State Paramedic License
   ☐ PALS or PEPP
   ☐ Other __________________________________________________________

This form completed by: ____________________________________________
Signature ___________________________ Date ________________________

Print Name ________________________________________________________

Note: At the time of hire of a Paramedic who possesses an S-SV Accreditation card, it is the responsibility of the S-SV ALS Service Provider to immediately verify S-SV Accreditation status with the S-SV EMS Agency.
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PURPOSE:

To establish a process by which eligible training providers, desiring to conduct S-SV EMS Agency approved Emergency Medical Responder (EMR) training courses, may apply for course approval and meet the established criteria for courses identified in this policy.

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, Section 100026.

POLICY:

The Sierra-Sacramento Valley Emergency Medical Services (S-SV EMS) Agency has the primary responsibility for approving and monitoring the performance of EMR training programs located within the S-SV EMS region, to ensure their compliance with state law, regulations, local policy and national standards/guidelines.

A. Eligible individuals, training agencies and institutions (other than statewide public safety agencies) intending to conduct an EMR Training Course shall secure program approval from the S-SV EMS Agency.

B. Previously established First Responder Training Programs in the S-SV EMS Region will have six (6) months from the effective date of this policy to obtain EMR program approval from the S-SV EMS Agency.

C. Other than the exception listed above, no EMR course shall begin instruction until that program has received written approval from the S-SV EMS Agency.

ELIGIBILITY FOR PROGRAM APPROVAL

In order to be approved as an S-SV EMS EMR training program provider, the provisions in this section shall be met.

A. An S-SV EMS approved EMR training program provider shall ensure that:
SUBJECT: EMERGENCY MEDICAL RESPONDER (EMR) TRAINING PROGRAM
REQUIREMENTS AND APPROVAL PROCESS

1. Course content meets or exceeds the standards and instructional guidelines established by the United States National Highway Traffic Safety Administration.

2. Records shall be maintained for four years and shall contain the following:
   a. Complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.
   b. Record of times, places, and dates each course is given.
   c. A roster of all students who participated in the EMR training course including information regarding whether the candidate passed or failed and any remediation that was provided.

B. The S-SV EMS Agency shall be notified within thirty calendar days of any change in name, address, telephone number, principal instructor or contact person.

C. All records shall be made available to the S-SV EMS Agency upon request. An EMR training program provider shall be subject to scheduled site visits by S-SV EMS Agency personnel.

D. Individual classes or activities shall be open for scheduled or unscheduled visits by S-SV EMS Agency personnel.

E. Each EMR training program provider shall provide for the functions of administrative direction, medical quality coordination and actual program instruction through the designation of a principle instructor and additional teaching assistants as necessary.

F. Each EMR training program provider shall have an approved Principle Instructor who meets the following minimum requirements:
   1. Currently certified or licensed in the State of California, at a minimum, as an EMT.
   2. Have at least one (1) year of EMS experience, at a minimum, as an EMT.
   3. Qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty hours 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) "Fire Instructor 1A and 1B"; or
b. National Fire Academy (NFA) "Fire Service Instructional Methodology" course; or

c. A training program that meets the U. S. Department of Transportation / National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the EMS Educator Course of the National Association of EMS Educators.

Individuals with equivalent experience may be provisionally approved for up to two years by the S-SV EMS Agency pending completion of the above specified requirements. Individuals with equivalent experience who teach in geographic areas where training resources are limited and who do not meet the above principle instructor requirements may be approved upon review of experience and demonstration of capabilities.

G. In addition to the approved principle instructor, each EMR training program may also utilize teaching assistants as necessary who meet the following minimum requirements:

1. Currently certified or licensed in the State of California, at a minimum, as an EMR.

2. Have at least one (1) year of EMS experience, at a minimum, as an EMR.

3. Have any combination of knowledge, skills and experience in teaching the course subject matter.

H. The S-SV EMS Agency shall be notified, in writing, within thirty (30) days of any change in program instructional staff.

I. All Certified, Authorized, or Licensed personnel involved in instruction shall be in good standing with their certifying, authorizing, or licensing authority. Good standing implies that no negative action to the certification, authorization, or license has been taken by the appropriate authority to the extent that it included revocation or suspension during the past two (2) years.

J. Maximum class size shall be determined by the number of instructors available, classroom space and amount of equipment available for skills teaching and testing.

1. An approved EMR training program provider shall ensure that there will be at least one principle instructor or teaching assistant for each 10 students during skills practice / laboratory sessions.

2. Classroom space, including any breakout skills rooms will be adequate in size and number for the amount of students being instructed.
3. Each principal instructor or teaching assistant shall have access to all equipment.

K. Each EMR training program provider will utilize a final written and skills examination approved by the S-SV EMS Agency.

L. Each EMR training program will provide the following documents, approved by the S-SV EMS Agency, to candidates who successfully complete the first responder training course:

1. EMR Course Completion Certificate.

2. S-SV EMS Agency EMR Certification application packet.

APPLICATION FOR APPROVAL

A. Eligible training providers wishing program approval shall contact the S-SV EMS Agency to request an EMR Training Program Provider Approval Packet.

B. A completed packet, including the following items, shall be submitted, to the S-SV EMS Agency for approval:


2. A statement verifying that the program meets or exceeds the National Highway Traffic Safety Administration Educational Standards and Instructional Guidelines which can be located at:

3. Samples of written and skills examinations used for student testing, including the proposed final written and skills examination.

4. The name and qualifications (resume) of the Principal Instructor and Teaching Assistants.

5. The location at which the courses are to be offered and their proposed dates.

6. A statement verifying that appropriate equipment and adequate classroom space is available for the classes to be taught.

C. The S-SV EMS Agency shall notify the eligible training provider within seven (7) working days of receiving the request that the request has been received and shall specify what information, if any, is missing.

D. The S-SV EMS Agency shall provide written notification of program approval or disapproval within 30 days of receipt of the application.
E. Program approval shall be granted for a four year period.

EMR TRAINING PROGRAM PROVIDER DISAPPROVAL

A. Noncompliance with any criteria required for EMR training program provider 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 EMR training program provider approval by the S-SV EMS Agency.

B. Notification of noncompliance and action to place on probation, suspend or revoke shall be carried out as follows:

1. The S-SV EMS Agency shall notify the approved EMR training program provider principal instructor in writing, by certified mail, of the provision of this Chapter with which the EMR training program provider is not in compliance.

2. Within fifteen days of receipt of the notification of noncompliance, the approved EMR training program provider 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 days from the date of receipt of the notification of noncompliance.

3. Within fifteen days of receipt of the response from the approved EMR training program provider, or within thirty days from the mailing date of the noncompliance notification if no response is received from the approved EMR training program provider, the S-SV EMS Agency shall notify the approved EMR training program provider in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, or place on probation, suspend or revoke the EMR training program provider approval.

4. If the S-SV EMS Agency decides to place on probation, suspend or revoke the EMR training program provider’s approval, the notification 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 days from the date of S-SV EMS Agency’s letter of decision to the EMR training program provider.

C. Nothing in this policy shall preclude the initial applicant, or previously approved EMR training program provider, from appealing a decision by S-SV EMS Agency
subject: emergency medical responder (emr) training program requirements and approval process

staff to deny approval or take action against an approved emr training program provider to the s-sv ems agency jpa board of directors.

Application for renewal

A. the EMR training program provider shall submit an application for renewal at least sixty calendar days before the expiration date of their EMR training program provider approval in order to maintain continuous approval.

B. all EMR training program provider requirements shall be met and maintained for renewal as specified in the section of this policy labeled ‘eligibility for program approval’.
# SIERRA-SACRAMENTO VALLEY EMS AGENCY

## PROCEDURE POLICIES

### SECTION XI

### SUBJECT:  INDEX

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SUBJECT: CO-OXIMETER DEVICES

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, Section 100146 & 100169

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.
**SUBJECT: CO-OXIMETER DEVICES**

**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.

CONTINUOUS QUALITY IMPROVEMENT

A copy of the completed PCR for any patient on whom a CO-Oximeter monitoring device is utilized must be forwarded to the S-SV EMS Agency within 30 days for Continuous Quality Improvement purposes.

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
  Contact Receiving Hospital

> 12%
- No further evaluation of SpCO needed
- Treat according to appropriate protocol based on patient presentation
- Contact Base Hospital if additional assistance is required
SUBJECT: ACCESSING A PRE-EXISTING VASCULAR ACCESS DEVICE

PURPOSE:

To provide vascular access utilizing a Pre-Existing Vascular Access Device (PVAD) for patients in extremis when no other vascular access is available.

AUTHORITY:


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

DEFINITION:

A Pre-Existing Vascular Access Device (PVAD) is an indwelling catheter / device placed into one of the central veins, to provide vascular access for those patients requiring long-term intravenous therapy or hemodialysis.

POLICY

Paramedics and Advanced EMTs 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.

INDICATIONS:

Only in the absence of any other observable vascular access, when the patient has:

A. Cardiopulmonary arrest
SUBJECT: ACCESSING A PRE-EXISTING VASCULAR ACCESS DEVICE

B. Extremis due to circulatory shock

C. Critical need for pharmacological intervention

COMPLICATIONS

A. Infection: Due to the location of the catheter, strict adherence to aseptic technique is crucial when handling a PVAD.

1. Use of sterile gloves is recommended;

2. Prep injectable port and surrounding skin with chlorhexidine prior to attaching I.V. tubing;

3. Use new supplies if equipment becomes contaminated;

4. 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

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.

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.
CONTINUOUS QUALITY IMPROVEMENT

A copy of the completed PCR for any patient on whom a pre-existing vascular access device is utilized must be forwarded to the S-SV EMS Agency within 30 days for Continuous Quality Improvement purposes.