Field Treatment Book
Selected MCEMSA Policies

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3505 Spangler Lane, Suite 405
Copperopolis, CA 95228
(209) 529-5085

ALS General Guidelines

Adult Treatment Guidelines

Pediatric Treatment Guidelines

Miscellaneous Policies

ALS General Guidelines

POLICY: 554.00
TITLE: General Protocols

EFFECTIVE: 9/16/2020
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PROTOCOLS

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

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

III. PROTOCOL

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

1. **General Procedures**
   a. Contains individual treatment procedures that can be found throughout MVEMSA protocols.
   b. "ALS" or Advanced Life Support procedures are procedures performed by a MVEMSA accredited Paramedic.
   c. "BLS" or Basic Life Support procedures are procedures performed by an individual providing care for an MVEMSA approved or recognized provider. We do not certify all individuals providing BLS care in our system.
   d. "
2. **Treatment Protocols**
   a. Adult – Patient's age 15 and older
   b. Pediatric –Patient's age 14 and younger

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

MEDICAL CONTROL

I. STANDING ORDERS

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

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

1. All BLS skills and treatment

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

II. BASE PHYSICIAN ORDERS

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

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

III. ALS WITHOUT BASE HOSPITAL CONTACT FORM

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

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

VASCULAR ACCESS

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

1. A PVAD should only be used when a life-threatening condition requires immediate fluid therapy or IV medications.

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

3. Aseptic technique must be followed.

4. Attempt to withdraw and discard 5 cc of blood from the device prior to infusion. If unable to withdraw, proceed with the infusion.

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

6. Follow manufacturer recommended settings and insertion techniques

TRANSPORT

I. TRANSPORT

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

II. Patient Destination:

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

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

C. During a declared MCI– patient destination will be at the direction of the Medical Group Supervisor based on location and availability of services.

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

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

RESPIRATORY GUIDELINES

A. Endotracheal Intubation:

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

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

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

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

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

MECHANICAL CHEST COMPRESSION DEVICE

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

II. **Indications**:

A. Patients 15 years of age or older

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

III. **Contraindications:**

A. Patients 14 years of age or younger

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

IV. **Procedure:**

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

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

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

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

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

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

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

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

I. Personnel that deploy a mechanical chest compression device shall ensure that a person trained and qualified to use the device accompanies the patient to the hospital, even if they are not the primary patient caregiver.

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

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

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

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

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

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

VI. **Quality Improvement:**

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

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

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

Adult Treatment Guidelines

POLICY: 554.04
TITLE: Symptomatic Bradycardia

EFFECTIVE: 9/16/2020
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SYMPTOMATIC BRADYCARDIA

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

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

III. PROTOCOL
Bradycardia may be secondary to sinus node disease, increased parasympathetic tone or drug effects (e.g. digitalis, beta-blockers, or calcium channel blockers). Heart rate is below 50 beats per minute, with associated signs/symptoms of low cardiac output. Never treat any bradycardia if the patient does not have serious symptoms.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Glucometer	Check blood sugar if patient displays signs of altered mentation
Pulse Oximetry	Report initial reading to paramedic if applicable
Mentation	If Altered Level of Consciousness check blood sugar and refer to 554.31 Altered Level of Consciousness if BGL<60mg/dl

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
IV/IO access	TKO. 250ml fluid challenge if systolic BP is <90mm/Hg. Repeat until BP improves
Cardiac monitor	Confirm heart rhythm and obtain 12 lead if time permits
Mentation	For Altered Level of Consciousness, refer to policy 554.31 Altered Level of Consciousness
Fentanyl	50mcg if systolic blood pressure is >90mm/Hg. Do not delay TCP for IV/IO access or pain management if the patient is unconscious
Consider Atropine	0.5-1.0 mg IV/IO push. Repeat every 3 minutes for max. total dose of 3 mg IV/IO. Use as low a dose as possible to reverse symptoms, especially in patients with suspected heart disease
Transcutaneous Pacing	For systolic <90mm/hg related to bradycardic rhythms (HR<50) and with serious signs and symptoms related to heart rate (severe chest pain, shortness of breath, Altered level of consciousness or congestive heart failure). If decreased rate and rhythm, are present, and serious signs and symptoms are exhibited proceed to intervention sequence. Follow manufacturer recommended settings.
Re-assessment	Observe for hemodynamic changes. Monitor patient. If pacer stops, do not make changes, patients heart rate might be above the pacer rate. Maintain current rate. If heart rate drops, the pacer will restart. Record and document vital sign q 5 minutes.

Clinical PEARLS

- Intravenous access is preferred over Intraosseous unless patient is unstable.
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage.
- High index of suspicion in a non-traumatic altered patient.
- The use of capnography is recommended and should be considered during the use of analgesia.

POLICY: 554.05
TITLE: Ventricular Tachycardia with Pulses

EFFECTIVE: 9/16/2020
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

VENTRICULAR TACHYCARDIA WITH PULSES

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

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

III. PROTOCOL
Regular or slightly irregular rhythm. Heart rate 100 to 200 (120 is common rate). A-V disassociation is present: P-waves may be seen unrelated to QRS complex. QRS complex distorted, wide (greater than 0.12 seconds) and bizarre. T-waves usually have opposite axis as QRS complex.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
Mentation	If Altered Level of Consciousness check blood glucose and refer to 554.31 Altered Level of Consciousness if BGL<60mg/dl

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
Cardiac Monitor	Identify heart rhythm and obtain 12-lead if time permits
IV/IO access	TKO. 250ml fluid challenge if systolic BP is <90mm/Hg. Repeat until BP improves
Amiodarone	If patient is stable, 150mg IV/IO infusion over 10 minutes. May repeat once if no change and patient remains stable
Lidocaine	If patient is stable 1.5mg/kg IV/IO. May repeat once at 0.75mg/kg IV/IO. Max total dose of 3mg/kg

Synchronized Cardioversion	If patient is unstable (chest pain or ALOC or shortness of breath or systolic BP < 90), perform at escalating doses per manufacturer recommendation. Repeat attempt x2 at next energy dose. If conversion is successful, administer Amiodarone 150mg IV/IO infusion over 10 minutes or Lidocaine 0.5mg/kg IV/IO repeat Lidocaine every 10 minutes until Max total dose of 3 mg/kg is achieved. Record and document vital signs q 5 minutes.
Fentanyl	Consider for pain management. 50mcg IV/IO push if systolic BP>100

Clinical PEARLS

- Intravenous access is preferred over Intraosseous unless patient is unstable.
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage.
- Obtain 12 lead post cardioversion and record findings in Patient Care Report.
- The use of capnography is recommended and should be considered during the use of analgesia.
- Never administer both Amiodarone and Lidocaine to the same patient.
- Reduce cardioversion dose by half for patient on Digitalis.
- If delays in synchronized cardioversion and patient is critical use unsynchronized shock.
- Avoid Lidocaine or Amiodarone post cardioversion if any AV Block or idioventricular dysrhythmias.
- Amiodarone is preferred in patients with known depressed ejection fraction (prior MI or CHF).

POLICY: 554.06
TITLE: Supraventricular Tachycardia

EFFECTIVE: 9/16/20
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SUPRAVENTRICULAR TACHYCARDIA

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

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

III. PROTOCOL
Always a very regular rhythm. Heart rate ranges 140 to 220 (usually 160-180). P waves unseen or abnormal. The QRS complex has normal duration (QRS less than 0.12). Remember that most SVT patients are young, and usually tolerate blood pressures of 80-90 without instability or deterioration.

Currently, cardiologists stress rhythm diagnosis of the SVT family over field treatment, and consider electrical cardioversion to be a late intervention, after multiple attempts of antiarrhythmic therapy. Treat only the sickest patients.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
Mentation	For Altered Level of Consciousness, check blood sugar and refer to 554.31 Alerted Level of Consciousness if BGL<60mg/dl

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
IV/IO access	TKO. 250ml fluid challenge if systolic BP is <90mmHg
Cardiac monitor	Identify heart rhythm and obtain 12 lead if time permits
Mentation	For Altered Level of Consciousness, refer to policy 554.31 Altered Level of Consciousness
Valsalva's Maneuver	Reassess for conversion.
Adenosine	For patients with systolic BP>90mmHg and severe chest pain or shortness of breath or altered level of consciousness or congestive heart failure, administer 6mg IV/IO push followed immediately by normal saline flush. A second dose of 12mg rapid IV/IO push may be administered if necessary
Synchronized Cardioversion	Synchronized cardioversion at escalating doses per manufacturers recommended setting if patient is unstable (systolic BP<90mmHg AND severe chest pain or shortness of breath or decreased level of consciousness or congestive heart failure). Monitor and document vital signs q 5 minutes
Fentanyl	50mcg if systolic blood pressure is >90mm/Hg. May be administered for pain management post cardioversion

Clinical PEARLS

- Obtain 12 lead post conversion and record findings in Patient Care Report.
- Intravenous access is preferred over Intraosseous unless patient is unstable.
- Manage airway with simplest technique. i.e.:BLS airway unless ineffective.
- The use of capnography is recommended and should be considered during the use of analgesia.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021

WIDE COMPLEX TACHYCARDIA OF UNCERTAIN TYPE

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

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

III. PROTOCOL: Wide complex tachyarrhythmia in which V-Tach and SVT cannot be distinguished. Risk factors are useful in distinguishing V-Tach from supraventricular tachycardia. Age greater than 70 years and prior history of ischemic heart disease strongly suggest V-Tach. Age less than 40 years and no history of ischemic heart disease strongly suggest SVT. Low blood pressure is not useful to distinguish between the two rhythms.

Wide Complex Tachycardia of Uncertain Type

History
- Age >70 and history of ischemic heart disease suggest V-Tach
- Age <40 and no history of ischemic heart disease suggest SVT

Signs and Symptoms
- Wide complex tachycardia in which V-Tach and SVT cannot be distinguished. Disassociation
- Unstable= Chest pain or ALOC or Shortness of breath or BP<90

Differential
- Ventricular tachycardia
- WPW with antidromic re-entry
- SVT with abberancy
- Atrial fibrillation with intraventricular conduction delay

B
- Assess CAB
- Secure airway with simplest effective method
- Oxygen delivery as appropriate

P
- Cardiac Monitor

A
- IV Access

P
- IV/IO Access

Stable?

Yes

P Obtain 12 Lead EKG

P IF THE RHYTHM IS REGULAR AND RATE >150:
Adenosine 6mg rapid push
followed immediately by saline flush.
May repeat at 12mg rapid push followed immediately by saline flush if no conversion

Convert?

Yes

No

Transport

No

P **Midazolam 2.0mg IV/IO/IN**
Do not delay cardioversion for IV sedation if patient is unconscious

P **Synchronized Cardioversion**
at escalating doses per manufacturers recommendation. Repeat attempt x2 at next energy dose.

Convert?
Max Attempts?

No

Yes

P
Amiodarone 150mg IV/IO
infusion over 10 minutes
OR
Lidocaine 0.5mg/kg IV/IO
Repeated every 10 minutes
Max 3mg/kg

- Treat Rhythm as Appropriate
- ALS Patient Management

Pearls

- NEVER give BOTH Lidocaine and Amiodarone to the same patient
- Cardiologists stress rhythm diagnosis over field treatment.
- Establish Base Hospital communication early for guidance.
- Obtain 12-Lead EKG in STABLE patients and consider transmitting for Physician consultation.
- Avoid Lidocaine OR Amiodarone post cardioversion if any AV Block or idioventricular dysrhythmias.

MVEMSA Policy 554.07

POLICY: 554.08
TITLE: Atrial Fibrillation – Atrial Flutter

EFFECTIVE: 10/21/2020
REVIEW: 10/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ATRIAL FIBRILLATION – ATRIAL FLUTTER

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

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

III. PROTOCOL
Atrial Fibrillation: The rhythm is irregularly irregular. Atrial rate 350 to 600 but as a rule cannot be counted. Ventricular rate is between 160 and 180 but may be much slower if patient is taking digoxin (lanoxin). Fibrillatory waves may be coarse or fine. QRS complex is usually normal. Most Atrial Fibrillation is longstanding, and is NOT the cause of the patient's chief complaint. In those cases, it should not be treated. In addition, any Atrial Fibrillation that has been present longer than 48 hours should not be treated, unless clearly unstable, to reduce the threat of thromboembolism after cardioversion.

Atrial Flutter: Atrial rhythm is regular. Ventricular rhythm may be regular or irregular if variable block is present. Ventricular rate is between 120 and 160 but may be slower if the patient is taking digoxin (lanoxin). QRS complex is usually normal and may follow every second, third, or fourth flutter wave. Atrial Flutter is rarely a longstanding rhythm. It commonly causes symptoms.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
Mentation	If Altered Level of Consciousness check blood sugar and refer to 554.31 Altered Level of Consciousness

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
Pulse Oximetry	
Mentation	If Altered Level of Consciousness check blood sugar and refer to 554.31 Altered Level of Consciousness
Cardiac Monitor	Identify heart rhythm and obtain 12 lead if time permits
IV/IO Access	TKO. 250ml fluid challenge if systolic BP is <90mm/Hg. Repeat until BP improves

Synchronized Cardioversion	**Unstable: Systolic BP<90mmHg AND severe chest pain, shortness of breath, decreased level of consciousness, or congestive heart failure:** SYNCHRONIZED at 100 J, 200 J, 300 J, 360 J (or clinically equivalent biphasic energy doses). Reduce power by half for patient taking digitalis. If delays in synchronization occur, and clinical conditions are critical, go to immediate unsynchronized shocks. Reassess and document vitals and rhythm post cardioversion
Fentanyl	50mcg if systolic blood pressure is >90mm/Hg. May be administered for pain management post cardioversion
Assessment	If systolic BP>90mmHg and no chest pain, shortness of breath, decreased level of consciousness or congestive heart failure: Monitor, IV access, and transport patient in position of comfort. Observe and reassess q 5 minutes. Document findings

Clinical PEARLS:

- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- The use of capnography is highly recommended in all Respiratory patients and during Analgesic use.
- Obtain 12 lead post conversion and document findings in Patient Care Report

POLICY: 554.09
TITLE: Coronary Ischemic Chest Discomfort

EFFECTIVE: 10/21/20
REVIEW: 10/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CORONARY ISCHEMIC CHEST DISCOMFORT

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

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

III. PROTOCOL
Characterized by: Substernal chest pain; chest or epigastric discomfort, heaviness, squeezing, burning or tightness; pain radiating to, or isolated to jaw, shoulders, arms or back; nausea; diaphoresis; dizziness; dyspnea; anxiety or back pain. Patient may have history of coronary artery disease. Up to 1/4 of coronary ischemia (Acute Coronary Syndrome) patients may have no chest discomfort at all-- this is more common in the elderly and diabetics.

Risk factors are more important than the pattern of chest discomfort. Prior history of ischemic heart disease, cigarette smoking, hypertension, high cholesterol, diabetes, and recent cocaine/amphetamine abuse are the strongest risk factors.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with BVM.

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
Mentation	If Altered Level of Consciousness check blood sugar and refer to 554.31 Altered Level of Consciousness
Aspirin	324 mg chewed PO unless taken within past 6 hours or has allergy to ASA
Nitroglycerin	EMT's may assist a patient with their prescribed sublingual NTG. 0.4 mg sublingual (if systolic BP > 100). May repeat every 3 minutes to a max of 3 total doses (including patient administered doses). Contact Base Hospital before administering nitroglycerin to patients taking Viagra (Sildenafil) within the past 6 hours.

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
Cardiac Monitor	12 Lead EKG – If interpretation results reveal ***ACUTE MI/SUSPECTED*** or manufacturer equivalent, expedite transport to SRC as directed if transport time is less than 60 minutes. Transmit 12-Lead EKG (if capable) to SRC upon immediate recognition. It is preferable to obtain 12 lead prior to Nitro administration or transport. Repeat post-treatment if patient symptomatic and condition permits.

Nitroglycerin 0.4 mg sublingual (if systolic BP > 100). May repeat every 3 minutes to a max of 3 total doses. Contact Base Hospital before administering nitroglycerin to patients taking Viagra (Sildenafil) within the past 6 hours.

IV/IO Access TKO. 250ml fluid challenge if systolic BP is <90mm/Hg. Repeat until BP improves

Pain Management If after 3 total doses of Nitroglycerin patient continues to experience pain refer to policy 554.44 Pain Management

Clinical PEARLS

- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- The use of capnography is highly recommended in all Respiratory patients and during Analgesic use.
- Patients in Amador, Calaveras and Mariposa counties meeting STEMI criteria shall be transported to closest facility if transport time to STEMI receiving facility is > 60 minutes and there are not contraindications to Thrombolytics
- EMS shall acquire 12 lead EKG on any suspected cardiac patient within 10 minutes of patient contact. If unable to obtain within 10 minutes the reason for delay shall be documented in the Patient Care Report.

POLICY: 554.10
TITLE: Congestive Heart Failure

EFFECTIVE: 10/21/2020
REVIEW: 10/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CONGESTIVE HEART FAILURE

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

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

III. DEFINITIONS

A. Mild Respiratory Distress describes a patient who is typically able to speak full sentences; whose blood pressure and pulse may be elevated; might be weak and diaphoretic; have a normal mental status; no cyanosis.

B. Moderate Respiratory Distress describes a patient who is generally able to speak just a few words; whose blood pressure and pulse are likely elevated; who might be weak and diaphoretic; have a normal mental status; circumoral and digital cyanosis may be present.

C. Severe Respiratory Distress describes a patient who is unable to speak; whose blood pressure and pulse will be elevated or depressed; whose mental status is typically altered; central cyanosis likely.

Note: Patients with congestive heart failure typically have a cardiac history, are generally older patients, and they are commonly on medications including beta blockers, diuretics, ACE inhibitors, digoxin, or calcium channel blockers. In addition, the CHF patient typically presents with physical findings including hypertension, peripheral edema, jugular venous distension, and a more sudden onset of wheezes, rales, or rhonchi, or some combination of all three. It is VERY UNLIKELY for a patient to have symptomatic CHF without a blood pressure >150 systolic. In these patients, oxygen (CPAP for Moderate/Severe) and direct vasodilators such as Morphine and Nitrates will be more efficacious than indirect venodilators such as Furosemide.

IV. PROTOCOL

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM
Position	Sitting (as tolerated.)
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable.
Position	Sitting (as tolerated.)

Mentation	for Altered Level of Consciousness, check blood sugar and refer to 554.31 Alerted Level of Consciousness
APPLY CPAP	If available and patient condition is Moderate or Severe respiratory distress, start at 5 cm H2O, titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H2O. CPAP is contraindicated in Patients that cannot maintain their own airway and/or an SBP< 90mmHg. Continue to record vital signs q 5 minutes including pulse oximetry readings.

PARAMEDIC STANDING ORDERS

Note	Must perform items in EMT standing orders if applicable
Cardiac Monitor	Identify rhythm and perform 12 Lead EKG – If interpretation results reveal ***ACUTE MI/SUSPECTED***, expedite transport to SRC as directed if transport time is less than 60 minutes. It is preferable to obtain 12 lead prior to Nitro administration or transport. Repeat post-treatment if patient symptomatic and condition persists.
Apply C-PAP	If available and patient condition is Moderate or Severe respiratory distress, start at 5 cm H2O, titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H2O. CPAP is contraindicated in Patients that cannot maintain their own airway and/or a SBP< 90mmHg. Continue to record vital signs q 5 minutes including pulse oximetry readings.
Nitroglycerine spray	0.4mg SL if systolic BP 120 – 150 mmHg 0.8mg SL if systolic BP 150 – 200 mmHg 1.2mg SL if systolic BP > 200 mmHg Recheck BP after each NTG dose. Repeat doses are based on systolic BP as outlined above. Repeat SL NTG every 5 minutes until clinical improvement or systolic BP 100 mmHg or less. Do not administer if systolic BP is less than 100 mmHg.
Nitroglycerine Paste	If CPAP is employed, apply 1 inch of NTG paste to anterior chest wall If CPAP is NOT employed, recheck BP after each NTG dose. Repeat SL doses are based on systolic BP as outlined above. Repeat NTG every 5 minutes until clinical improvement or systolic BP 100 mmHg or less. Do not administer if systolic BP is less than 100 mmHg.
Albuterol	2.5mg (3ml unit dose) via handheld nebulizer/in line nebulization if the patient is wheezing
IV/IO access	Saline Lock is preferable. Be cautious on fluid administration
Morphine	Consider 2.0 mg slow IV/IO if systolic BP > 100 mmHg for patients in severe distress. May repeat ONCE.
Push Dose EPINEPHRINE	0.2ML IV/IO of 1:10,000 every 5 minutes to maintain systolic BP>90 mmHg

Clinical PEARLS:

- Intravenous access is preferred over Intraosseous unless patient is unstable.
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage.
- Patients in Amador, Calaveras and Mariposa counties meeting STEMI criteria shall be transported to closest facility if transport time to STEMI receiving facility is > 60 minutes and there are not contraindications to Thrombolytics.
- EMS shall acquire 12 lead EKG on any suspected cardiac patient within 10 minutes of patient contact. If unable to obtain within 10 minutes the reason for delay shall be documented in the Patient Care Report.

- CPAP is only indicated on patients in moderate and severe respiratory distress and do not have contraindications. Contraindications to CPAP include: Patients < 15 years old, patients less <4 feet tall, patients with an altered mental status, patients without an intact gag reflex and patients with systolic blood pressure < 90mmHg

POLICY: 554.11
TITLE: Cardiac Arrest Algorithms

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CARDIAC ARREST ALGORITHMS

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

II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice. To allow for the discontinuation of pre-hospital resuscitation by Paramedics in adult medical cardiac arrests after the delivery of adequate and appropriate ALS therapy.

III. PROTOCOL

A. HIGH PERFORMANCE CPR

The absence of a detectable pulse in the adult, medical cardiac arrest. Contraindicated in the patient with a valid DNR/POLST form and those meeting "Obviously Dead" criteria (policy 570.20). *Refer to High Performance CPR Algorithm for treatment standard.*

B. VENTRICULAR FIBRILLATION - PULSELESS VENTRICULAR TACHYCARDIA

V-FIB: Bizarre, rapid, irregular, ineffective rhythm with electrical waveforms varying in size and shape. There is no P wave. QRS complexes are absent. V-fib may masquerade in one lead as asystole. Be sure to check at least two leads to confirm asystole. **V-TACH**: Regular or slightly irregular rhythm with no pulse. Heart rate 100 to 200 (commonly about 120). A-V disassociation is present: P-waves may be seen unrelated to QRS complex. QRS complex distorted, wide (> 0.12 seconds) and bizarre. T-waves usually have opposite axis as QRS complex. Perform 12 Lead EKG if return of spontaneous circulation (ROSC). *Refer to Ventricular Fibrillation/Pulseless Ventricular Tachycardia Algorithm for treatment standard.*

C. PULSELESS ELECTRICAL ACTIVITY

The absence of a detectable pulse and the presence of some type of regular electrical activity other than V-Tach define this group of arrhythmias. Many of these patients do have cardiac mechanical activity without effective cardiac output (they are in profound shock). This category includes Electromechanical Dissociation (EMD), Idioventricular rhythms, Pseudo-EMD,
and Bradycardic rhythms. Perform 12 Lead EKG if return of spontaneous circulation (ROSC). *Refer to Asystole/Pulseless Electrical Activity Algorithm for treatment standard.*

Consider Possible Causes:

HYPOVOLEMIA (volume infusion)
PULMONARY EMBOLISM
HYPOXIA (ventilation)
DRUG OVERDOSE (appropriate antidote)
CARDIAC TAMPONADE
HYPERKALEMIA (sodium bicarb, calcium chloride)
TENSION PNEUMOTHORAX (needle decompression)
ACIDOSIS (ventilation)
HYPOTHERMIA (refer to Hypothermia Policy 554.62)
MYOCARDIAL INFARCTION

D. ASYSTOLE

Asystole represents the total absence of electrical activity in the ventricle. There is no rhythm, although an occasional P-wave or agonal QRS may be seen. Heart rate is less than five beats per minute. Note: Asystole should be confirmed by at least two leads, since low-amplitude ventricular fibrillation can mimic asystole. Perform 12 Lead EKG if return of spontaneous circulation (ROSC). *Refer to Asystole/Pulseless Electrical Activity Algorithm for treatment standard.*

E. POST ARREST RESUSCITATION ALGORITHM

Return of Spontaneous Circulation (ROSC) post-cardiac or respiratory arrest. Perform 12 Lead EKG if Return of Spontaneous Circulation (ROSC) and transport all VF/PVT and STEMI patients to a STEMI Receiving Center if transport time is less than 60 minutes (air or ground). *Refer to Post Arrest Resuscitation Algorithm for treatment standard.*

F. TERMINATION OF RESUSCITATION- ADULT MEDICAL CARDIAC ARREST

Cardiopulmonary resuscitation (CPR) and advanced live support (ALS) interventions may be discontinued prior to transport when this procedure is followed. *Refer to the Termination of Resuscitation- Adult Medical Cardiac Arrest guidelines for treatment standard.*

High Performance CPR Algorithm

Criteria for Death/No Resuscitation
Review DNR/POLST form

Yes → Do NOT begin resuscitation Refer to Determination of Death Protocol

No

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Arrest Resuscitation Protocol

Pearls

- **Deliver 30 compressions while the AED is charging when "Shock Advised"**
- **BVM should be 2 person, with a rescuer using 2 hand grip**
- **Delivering slow, one hand BVM ventilations**

First BLS/ALS Responder (Rescuer #1)

- Move Patient to Workable Area
- Open Airway
- Initiate Compressions ONLY CPR
- Alternate with Rescuer #2

Second BLS/ALS Responder (Rescuer #2)

- Remove Patient Shirt
- Attach AED/Defib pads
- Start metronome
- Insert OPA
- Start high flow oxygen via NRB
- Defibrillation as necessary
- Alternate with Rescuer #1

Rescuer #3

BLS

B

- Begin 2 person BVM Ventilations @ 2/minute
- Attached ETCO2 when available
- Compression Coach
- 2 Minute Cycle Timer
- Defibrillation with AED

ALS

A

- Begin 2 person BVM Ventilations @ 2/minute
- Attach ETCO2 when available
- Compression Coach
- 2 Minute Cycle Timer
- Defibrillation with AED
- Insert a Perilaryngeal Airway (if difficult or unmanageable BLS airway)

P

- Cardiac Monitor
- Defibrillation
- Intubation (if difficult or unmanageable BLS airway)

Rescuer #4 (ALS Responder)

A

- IV Access
- Administer medications
- Defibrillation
- Insert perilaryngeal airway (if difficult or unmanageable BLS airway)

P

- IO Access (if no IV)
- Intubation (if difficult or unmanageable BLS airway)

MVEMSA Policy 554.11

Ventricular Fibrillation/Pulseless Ventricular Tachycardia Algorithm

History	Signs and Symptoms	Differential
• Events leading to arrest • Estimated downtime • Past medical history • Medications • DNR/POLST forms • Renal Failure/Dialysis	• Unresponsive • Apneic • Pulseless • VF/Pulseless VT on EKG	• Primary Cardiac • Endocrine • Drugs/Medication • Pulmonary

High Performance CPR Algorithm

P Defibrillate

B	• Resume CPR WITHOUT pulse check • Change compressors every 2 minutes • Limit any pauses to <6 seconds
A	Start IV
P	**Epinephrine (1:10000) 1 mg IV/IO** Repeat every 3-5 minutes

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Arrest Resuscitation Protocol

B	• Pre-charge the defibrillator • Locate pulse during compressions • Pre-shock pause <3 seconds
P	**Defibrillate** Post-shock Pause <3 seconds

B	• Resume CPR WITHOUT pulse check • Change compressors every 2 minutes • Limit any pauses to <6 seconds		
P	**Lidocaine 1.5 mg/kg IV/IO** May repeat x1 in 4 minutes if VF/VT persists	**OR**	**Amiodarone 300mg IV/IO** May repeat with 150mg IV/IO in 4 minutes if VF/VT persists
P	**Defibrillate** (Post-shock Pause <3 seconds)		

B	Continue High Quality, Continuous Compressions
P	Sodium Bicarbonate 1 mEq/kg IV/IO (Max 100 mEq) for Dialysis patients or suspected hyperkalemia
	Calcium Chloride 1 g IV/IO for Dialysis patients/suspected hyperkalemia

Pearls

- **ROTATE compressors every 2 minutes to assure high quality CPR**
- **DO NOT over-ventilate**
- **AVOID PAUSES**
- **WATCH THE RATE (maintain compressions at 110-120/ minute)**
- **Defibrillation is ALWAYS at maximum dose per manufacturer's recommendations**
- **Defibrillation should occur with every 2 minute cycle**
- **VF/PVT does not meet Termination of Resuscitation criteria until 40 MINUTES following start of ETCO2 monitoring**

Return of Spontaneous Circulation

No

Yes

Exit to **Return of Spontaneous Circulation Protocol**

MVEMSA Policy 554.11

Asystole/Pulseless Electrical Activity Algorithm

History	Signs and Symptoms	Differential
• Events leading to arrest • Estimated downtime • Past medical history • Medications • DNR/POLST forms • Renal Failure/Dialysis • Suspected Overdose • Suspected hypothermia	• Unresponsive • Apneic • Pulseless • Asystole or PEA on cardiac monitor	• Hypovolemia (trauma/AAA) • Hypothermia • Hypoxia • Pulmonary Embolus • Hyperkalemia • Cardiac tamponade • Drug overdose • Acute MI

High Performance CPR Algorithm

B
- Resume CPR WITHOUT pulse check
- Change compressors every 2 minutes
- Limit any pauses to <6 seconds

P Cardiac Monitor

Shockable Rhythm?

Yes → Follow Appropriate Rhythm Protocol

No

B
- Resume CPR WITHOUT pulse check
- Change compressors every 2 minutes
- Limit any pauses to <6 seconds

Search for **REVERSIBLE** causes

A Start IV **P** Start IO

Epinephrine (1:10000) 1 mg IV/IO
Repeat every 3-5 minutes

Normal Saline Bolus 1000ml IV/IO

Criteria for Termination of Resuscitation Efforts?

Yes → Exit to **Termination of Resuscitation Protocol**

No

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Arrest Resuscitation Protocol

Reversible Causes
- Hypovolemia
- Hypoxia
- Hydrogen Ion (Acidosis)
- Hypothermia
- Hypo/Hyperkalemia
- Hypoglycemia
- Tension Pneumothorax
- Tamponade, Cardiac
- Toxins
- Thrombosis (MI and PE)

Consider EARLY for PEA
- Repeat Saline boluses if suspected hypovolemia
- D50% IV/IO (hypoglycemia)
- Naloxone 2 mg IV/IO/IM/IN (suspected opiate OD)
- Glucagon 2 mg IV/IO/IM (suspected beta-blocker or calcium channel blocker OD)
- Calcium chloride 1 g IV/IO (suspected hyperkalemia)
- Sodium bicarbonate 100 mEq IV/IO (suspected renal failure/ hyperkalemia/OD)
- Chest decompression (suspected tension pneumothorax)

MVEMSA Policy 554.11

Post Arrest Resuscitation Algorithm

History	Signs and Symptoms	Differential
• Respiratory Arrest • Cardiac Arrest	• Return of Pulse	• Continue to address specific differentials associated with the original dysrhythmia

Repeat Primary Assessment
DO NOT move the patient for at least 5 minutes to allow for post-arrest stabilization

Optimize Ventilation

- Maintain ETCO2 35-45 (roughly 6-12 ventilations/minute)
- DO NOT HYPERVENTILATE

A	• Start IV • Perilaryngeal airway, as indicated	P	• Start IV/IO • Advanced airway, as indicated
P	Cardiac Monitor 12 Lead EKG		

↓

STEMI?

YES → Refer to STEMI Triage and Destination Policy (530.00)

No ↓

VF/PVT Arrest?

YES → Transport to nearest STEMI Receiving Center if total transport time is <60 minutes. Consider helicopter if >60 minutes transport. Otherwise, transport to closest facility

No ↓

Hypotension Systolic BP <90

YES →

A	Normal Saline Bolus 500ml IV/IO. Repeat as needed if lungs clear (Max 2000 mL)
P	Push dose Epinephrine: 0.2ml of 1:10,000 every 5 minutes to achieve systolic BP >90mmHg

No ↓

Arrythmias Present

Yes ↓

Arrythmias are COMMON and often self limited following ROSC. Avoid antiarrythmics as they may worsen cardiac conduction and promote arrythmias

If patient returns to cardiac arrest, follow the appropriate algorithm corresponding to the rhythm.

MVEMSA Policy # 554.11

Termination of Resuscitation – Adult Medical Cardiac Arrest

Policy:
Cardiopulmonary resuscitation (CPR) and advanced life support (ALS) interventions may be discontinued prior to transport when this procedure is followed.

Purpose:
To allow for the discontinuation of pre-hospital resuscitation in adult medical cardiac arrests after the delivery of adequate and appropriate ALS therapy.

Procedure:
CPR and ALS interventions may be discontinued if **ALL** of the following criteria have been met:

- Patient has suffered a presumed medical (non-traumatic) cardiac arrest,
- Patient is NOT pregnant,
- Patient is not a victim of hypothermia or drowning/submersion,
- Arrest was not witnessed by EMS providers,
- Adequate High Performance CPR (HPCPR) has been administered,
- Airway has been successfully managed. Acceptable management techniques for this policy include effective BLS airway maneuvers, a perilaryngeal airway, or endotracheal intubation (ETI),
- IV or IO access has been achieved,
- Rhythm appropriate medications and defibrillation have been administered according to algorithm *and*
- One of the three following criteria has been met:

Persistent ASYSTOLE with ETCO2 <10 despite effective and continuous HPCPR	Persistent ASYSTOLE with ETCO2 >10 with effective and continuous HPCPR	VF/PVT/PEA, with or without rhythm changes
May discontinue resuscitative efforts after 20 minutes from start of ETCO2 monitoring Make Base Contact	May discontinue resuscitative efforts after 30 minutes from start of ETCO2 monitoring Make Base Contact	May discontinue resuscitative efforts after 40 minutes from start of ETCO2 monitoring Make Base Contact

Important Pearls

- Changing rhythms from asystole to PEA, PEA to VF/PVT is a POSITIVE sign that therapy is effective. Keep working!
- ETCO2 is an excellent tool to determine adequacy of compressions and potential for resuscitation. ETCO2 readings persistently below 20 despite adequate CPR is a POOR prognostic indicator. However, climbing ETCO2 levels above 20 with adequate CPR indicate metabolically favorable changes ongoing with the resuscitation. Keep working!
- Expect resuscitative efforts to be long and demanding, every time! Keep working!
- Documentation is KEY! Be sure to include ETCO2 readings throughout resuscitation. Document medications given and response to the medications. Document reasons for termination.

MVEMSA Policy # 554.11

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.21
TITLE: Airway Obstruction

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

AIRWAY OBSTRUCTION

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

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

III. DEFINITIONS: Partial Obstruction: Stridor, coughing forcefully, able to speak, still passing some air.
Complete Obstruction: Cyanosis, silent cough, unable to speak, no air movement.

IV. PROTOCOL: Consider the cause of the airway partial or complete obstruction, support ABC's.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Record reading
Paramedic STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
IV/IO Access	TKO
Needle Cricothyrotomy	If unable to manage airway by any other method, a catheter-over-needle, maximum gauge of 10, attached to a 50 psi transtracheal oxygen ventilation system.

Clinical PEARLS:

- **PARTIAL OBSTRUCTION**-
  Foreign body- Observe patient, supportive care
  Angioedema-Position of comfort. Paramedics-Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless tracheal intubation required.
  Trauma-Suction; supportive care.
  Anaphylaxis-Refer to Allergic Reaction Policy 554.43
- **COMPLETE OBSTRUCTION**
  Foreign body- Abdominal thrusts (chest thrusts for pregnant patients). Paramedics- laryngoscopy and removal with Magill Forceps.
  Angioedema- Position of comfort. Paramedics-Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless endotracheal intubation required.
  Trauma- Aggressive suctioning, supportive care, secure airway as appropriate
- **UNCONSCIOUS PATIENT**
  CPR-Refer to Cardiac Arrest Algorithm
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage

POLICY: 554.23
TITLE: Tension Pneumothorax

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TENSION PNEUMOTHORAX

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

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

III. PROTOCOL
Physical signs may include: Systolic BP < than 90, altered level of consciousness, chest pain, decreased breath sounds, increased resonance on side of collapsed lung, Jugular Venous Distension (JVD), tracheal deviation away from side of collapsed lung, asymmetrical chest motion and/or crepitus.

Multi-system trauma and scene conditions often make diagnosis difficult. Remember, **this is a rapid obstructive shock**, NOT a respiratory problem

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate
Bleeding control	Direct pressure with appropriate bandage. Apply occlusive dressing as needed

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
Needle Thoracostomy	10 or 12 gauge or approved NCD kit. Minimum 3.25-inch length inserted into affected side in the second intercostal space, mid-clavicular line. Perform on other side if no response to treatment and the tension pneumothorax physiology persists. Secure catheter
IV/IO Access	Two large bore IV/IO. If systolic BP is < than 90, give 250 ml boluses to systolic until BP 90 mmHg. Reassess after each bolus
Observe	Continue to monitor for signs of recurrence of a tension pneumothorax and for obstruction or dislodgement of thoracostomy catheter

Clinical PEARLS:

- Needle Thoracostomy may only be performed on second intracoastal, mid-clavicular site
- Record and document pulse oximetry readings pre and post procedure
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Intravenous access is preferred over Intraosseous unless patient is unstable

POLICY: 554.24
TITLE: Respiratory Distress

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

RESPIRATORY DISTRESS

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

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

III. DEFINITIONS

A. Mild Respiratory Distress describes a patient who is typically able to speak full sentences; whose blood pressure and pulse may be elevated; might be weak and diaphoretic; have a normal mental status; no cyanosis.

B. Moderate Respiratory Distress describes a patient who is generally able to speak just a few words; whose blood pressure and pulse are likely elevated; who might be weak and diaphoretic; have a normal mental status; circumoral and digital cyanosis may be present.

C. Severe Respiratory Distress describes a patient who is unable to speak; whose blood pressure and pulse will be elevated or depressed; whose mental status typically altered; central cyanosis likely.

Note: Sometimes patients do not fall clearly into a specific treatment protocol, especially for respiratory distress. Examples might include patients suffering from pneumonia. For those patients where a specific treatment protocol does not fit the patient's presentation, this protocol may be utilized.

IV. PROTOCOL

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q 5 minutes and place patient in position of comfort
Oxygen Administration	Provide oxygen if appropriate.
Position	Sitting (as tolerated).

EMT STANDING ORDERS	
Note	Must perform items in EMR standing order if applicable
Temp	Record and document temperature
Pulse Oximetry	Record reading pre and post oxygen administration.
CPAP	Consider CPAP for patients in moderate and severe respiratory distress. If available, start at 5 cm H2O titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H2O

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT Standing orders if applicable
Monitor	Treat heart rhythm as appropriate
Albuterol	5mg (6ml unit dose) via handheld/mask nebulizer/in line nebulization continuously if still wheezing
IV/IO Access	TKO

Clinical PEARLS:

- Consider sepsis as an underlying condition
- Consider the use of ETCO2
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Consider Epinephrine 0.3mg of 1:1000 IM, if age <40 years old and systolic BP <180mm Hg.
- Acquire 12 lead if cardiac event is suspected
- Obtain and report home 02 level
- CPAP is only indicated on patients in moderate and severe respiratory distress and does not have any contraindications. Contraindications to CPAP include: Patients < 15 years old, patients less <4 feet tall, patients with an altered mental status, patients without an intact gag reflex and patients with systolic blood pressure < 90mmHg

POLICY: 554.31
TITLE: Altered Level of Consciousness

EFFECTIVE: 6/10/20
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALTERED LEVEL OF CONSCIOUSNESS

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

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

III. PROTOCOL
Characterized by a Glasgow Coma Score less than 15, confusion or unconsciousness or a change from baseline.

EMR Standing Orders	
Patient Assessment	Circulation, Airway and Breathing, asses vitals q 5 minutes and consider trauma mechanism
Oxygen Administration	Maintain airway and provide oxygen as appropriate
Bleeding Control	Direct pressure with appropriate bandage

EMT Standing Orders	
Note	Must perform items in EMR standing orders as appropriate
Glucometer	Check blood sugar
Pulse oximetry	Report initial reading to paramedic if applicable
Glucose	Oral glucose if patient can protect airway and has a gag reflex if blood sugar is <60mg/dl
Naloxone	2 mg IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

	Paramedic Standing Orders
Note	Must perform items in EMR and EMT standing orders as appropriate
Monitor	Treat heart rhythm as appropriate
Temp	Consider sepsis for any altered patient with a fever
IV/IO Access	TKO. If systolic BP is < 90mmHg, give 250ml fluid boluses to systolic BP 90-100 or a max of 2 liters. Shall reassess vitals/patient after each bolus
Dextrose	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
Glucagon	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose.
Naloxone	2 mg IV/IO/IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose. Max of two doses total
Base Physician Contact-	
Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released at scene if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.	

Clinical PEARLS

- High index of suspicion of sepsis in a non-traumatic altered patient
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 250ml drip if D50w is unavailable and BG <60. Continue D-10W until patient symptoms improves
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Naloxone- May use the prescribed grant administered aerosol 4mg doses if that's all that's available
- Naloxone must be administered prior to intubation if narcotic overdose is suspected

POLICY: 554.33
TITLE: Seizures

EFFECTIVE: 12/23/20
REVIEW: 12/2020
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SEIZURES

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

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

III. PROTOCOL
An actively seizing patient who has been seizing for more than 5 minutes, or an actively seizing patient with recurrent seizures, with no reawakening in between seizures is defined as Status Epilepticus.

Seizures from any cause are managed similarly, including those caused by epilepsy, infection, fever, intoxication, poisoning, or eclampsia.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess Vitals q5 minutes
Airway Control	Prepare to suction if needed
Oxygen Administration	Provide oxygen if appropriate
Position	Place on left side if possible, protect patient from injury
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Glucometer	Check blood sugar
Pulse Oximetry	Report initial reading to paramedic
Temp	Consider sepsis for any altered patient

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat rhythm as appropriate
IV/IO access	TKO
Midazolam	If Status Epilepticus-Intravenous or intraosseous give 2.0 mg initial dose, titrate 1 mg increments for seizure control, for max dose of 6 mg. If unable to establish IV/IO, give 5 mg intranasal (2.5 mg in each nares) or a one-time dose of 5 mg intramuscular
Dextrose	25 gms IV/IO push – if blood glucose < than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes after each dose
Glucagon	If no IV/IO access immediately available with blood glucose < than 60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose in 5 minutes after each dose
Base Physician Orders	**RELEASE-AT-SCENE Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.**

Clinical PEARLS:

- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage

POLICY: 554.40
TITLE: Sepsis

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

SEPSIS

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

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

III. PROTOCOL
Sepsis is a life-threatening, systemic infection with treatment centering on early recognition, hospital notification, fluid replacement and early antibiotics.

Sepsis

Risk Factors	Signs/Symptoms	Differential
• Age (elderly/newborn) • Diabetes • Immune compromise • Alcoholism/IV drug abuse • Malnutrition • Recent surgery • Indwelling devices (Foley, IV lines) • Renal Disease	• SIRS (Systemic Inflammatory Response Syndrome) which is **two or more** of the following: Temperature >100.4F or <96F Heart Rate > 90 Respiratory Rate > 20	• Hypovolemia • Hypothermia • Adrenal Crisis • Thyroid Storm • Anticholinergic Crisis • Overdose (eg: Aspirin)

Does patient have suspected or documented infection?

No → Observe and monitor

Yes

Does the Patient meet TWO or more of the following SIRS criteria?
Temp > 100.4 or <96
HR > 90
RR > 20

No → Observe and monitor

Yes

A	Call **"Sepsis Alert"** to Receiving Hospital	
	Start IV	P Start IO
	Normal Saline bolus 500cc IV/IO. Reassess vitals and lung sounds after each 500cc bolus. May repeat 500cc boluses IV/IO until 20cc/kg is administered **OR** BP > 100 systolic **AND** HR < 90. Hold repeat boluses if signs of volume overload.	
	• Obtain finger stick blood glucose	
P	• Apply **ETCO2** • Obtain finger stick **lactate**, if available • Push dose Epinephrine 0.2ml of 1:10,000 every 5 minutes to achieve systolic BP >90 mmHg	

PEARLS

- **"SIRS" means Systemic Inflammatory Response Syndrome.**
- **SIRS + Infection = SEPSIS**
- **Temperature is extremely useful in identifying SIRS**
- **Patient's with Sepsis are volume depleted, and can require significant boluses of fluid**
- **A numerical ETCO2 value should be documented as early as possible after first bolus is begun, and repeat measurement should be documented on hospital arrival as well.**
- **Finger stick lactate is not mandatory, only if proper equipment is available. One lactate value should be documented in the PCR.**

MVEMSA Policy # 554.40

POLICY: 554.41
TITLE: Non-Traumatic Shock

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NON-TRAUMATIC SHOCK

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

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

III. PROTOCOL
History may include: GI bleeding, vomiting, diarrhea, allergic reaction, fever, sepsis, anti-hypertensive overdose.

Physical signs may be due to circulatory insufficiency (collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse) or sympathetic compensation (pale, cold, clammy, mottled skin, rapid respirations, anxiety). Signs of compensation may be absent in the elderly, children, or patients taking vasoactive medications. **NOTE**: A decreased blood pressure is a late sign of shock.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Position	Place patient supine with legs elevated
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat rhythm as appropriate

IV/IO Access	Two large bore access points. If systolic BP<90mmHg, give 500ml boluses to achieve systolic BP 90-100. Reassess the patient after each bolus. Max of 2000ml total
Push Dose Epinephrine	0.2ml of 1:10,000 IV/IO every 5 minutes to maintain systolic BP >90mmHg if unsuccessful after 1000ml of fluid. Consider early for patients with history of CHF
CONSIDER CAUSE	Cardiogenic – IV fluid boluses Septic shock-Refer to Sepsis 554.40 DKA-IV fluids, Refer to Blood Sugar Emergencies 554.42 Overdose-refer to Poisoning/Overdose 554.51 Hypovolemia – IV fluid boluses Hypoxia – Oxygenate/Ventilate and assist ventilations as necessary Anaphylaxis – refer to Allergic Reaction Policy 554.43

Clinical PEARLS:

- Continuous assessment for signs of fluid overload, especially for patients with known CHF
  Consider Sepsis as underlying cause for tachycardic and hypotensive patients when no evidence of trauma is present.

POLICY: 554.42
TITLE: Blood Sugar Emergencies

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

BLOOD SUGAR EMERGENCIES

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

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

III. PROTOCOL
Blood sugar testing is the only accurate method to determine if a patient is hypoglycemic or hyperglycemic. Symptoms are not specific.

Hypoglycemia: Blood glucose < than 60mg/dl. Characterized by: ALOC, seizures, combativeness, disorientation, diaphoresis, shaking.

Hyperglycemia: Often triggered by an underlying infection. Characterized by: thirst and increased urination, confusion, dehydration, deep, and rapid respirations, nausea, vomiting, fruity odor on breath, missed insulin dose.

EMR STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate

EMT STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Note	Must perform items in EMR standing orders if applicable
Glucometer	Check blood sugar
Glucose	Oral glucose (one tube) 37.5 gram's if patient can protect airway and has a gag reflex if blood sugar is <60mg/dl. no repeat doses
Pulse Oximetry	Report initial reading to paramedic if applicable

PARAMEDIC STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
IV/IO Access	If blood sugar is too high to measure, the patient is clinically dehydrated (dry mucous membranes, poor skin turgor, tachycardia, etc), AND the patient is not on dialysis, CONSIDER 500 ml bolus of normal saline
Dextrose	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
Glucagon	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose
Base Physician Orders	RELEASE-AT-SCENE: Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35

Clinical PEARLS:

- Dextrose 10% IV Piggyback or IV drip, hang a 250 bag of 10% dextrose either piggyback to the normal saline bag or directly to IV hub/saline lock. Administer 100-200ml bolus. Reassess between boluses for improvements. If D-50 is not available
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage

POLICY: 554.43
TITLE: Allergic Reaction - Anaphylaxis

EFFECTIVE: 6/10/20
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALLERGIC REACTION - ANAPHYLAXIS

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

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

III. PROTOCOL

STANDING ORDERS

ALLERGIC REACTION (Hives, Rash, Swelling): A local response to an antigen involving the skin (rash, hives, edema, etc) with normal vital signs. Any involvement of the respiratory system (wheezing, stridor), or oral/facial edema, will be treated as anaphylaxis. Remember that allergic reactions may escalate into anaphylaxis - reassess often and be prepared to treat for anaphylaxis.

ASSESS	CAB
REMOVE ALLERGEN	If possible (e.g. bee stinger) and apply ice to site.
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO
DIPHENHYDRAMINE	25 mg IV/IO push. May administer 25 mg IM if IV/IO access not promptly available.

ANAPHYLAXIS (Wheezing, stridor, hypotension, severe respiratory depression, oral swelling, altered mental status, chest tightness): A systemic response to an antigen involving two (2) or more organ systems **OR** any deterioration of vital signs.

ASSESS	CAB
REMOVE ALLERGEN	If possible (e.g. bee stinger) and apply ice to site.
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
EPINEPHRINE	0.3 mg of 1:1000, IM. May repeat every 15 minutes
	(EMTs may use either Epinephrine by auto-injector OR an Agency approved Epinephrine injection kit. 0.3mg 1:1000. NO repeat doses permitted)
IV/IO ACCESS	Two 14-16 gauge IVs.
	If systolic BP is less than 90mmHg, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.

	Consider 0.2ml of 1:10,000 IV/IO every 5 minutes to maintain systolic BP > 90mmHg
PUSH DOSE EPINEPHRINE	
DIPHENHYDRAMINE	50 mg IV/IO push. May administer 50 mg IM if IV/IO access not promptly available.
ALBUTEROL	If wheezing or stridor: 3.0ml of 0.5% solution in 15ml saline (or 6 unit dose vials) continuous nebulization via hand-held nebulizer, mask, or in-line with CPAP over 1 hour, or until symptoms improve. If patient intubated, administer dose through in-line aerosolized method. Repeat as needed.

POLICY: 554.44
TITLE: Pain Management

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAIN MANAGEMENT

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

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

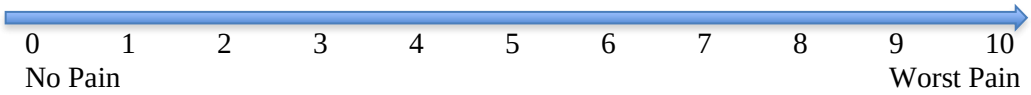
III. PROTOCOL
Every patient deserves to have his or her pain managed. Consider reassurance, position of comfort, ice and gentle transport as part of pain management. Privacy and separation from parents may benefit adolescents. Do not attempt to completely relieve the patient's pain, but treat aggressively enough to make it bearable.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Pain Management	Apply ice pack on affected area. Prevent direct skin contact with a barrier between ice pack and skin
Splinting	Splint affected limb in position of comfort

EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
IV/IO Access	TKO
Morphine	If BP is >90 systolic-5mg initial dose IV/IO. May administer 1 additional dose of 5 mg IV/IO after 10 minutes if pain is not controlled. If no IV/IO access, give a 1-time dose of 5 mg intramuscular.
Fentanyl	I BP is > 90 systolic -50 mcg IV/IO/IN every 5 minutes. Max of 3 doses total

This is the official pain scale to be used in patient assessment and documented on the PCR. Document a minimum of two pain scales (initial and on arrival at hospital).



Clinical PEARLS:

- Morphine is BETTER for Visceral pain; Fentanyl for Somatic pain (try to use them this way if BOTH are carried)
- ETCO2 shall be used and documented when analgesia is given
- Base Physician Order is required for additional analgesia

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POLICY: 554.45
TITLE: Non-Traumatic Abdominal Pain

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NON-TRAUMATIC ABDOMINAL PAIN

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

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

III. PROTOCOL
It is important to remember that serious medical conditions can produce symptoms like abdominal pain such as a cardiac event and sepsis, Ascites, Abdominal Aortic Aneurysm, Referred Pain, and Kidney Stones. Conduct a detailed exam to determine underlying cause and location.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
EMT STANDING ORDERS	
Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain blood glucose level
PARAMEDIC STANDING ORDERS	
Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat rhythm as appropriate

IV Access	Establish an IV and titrate to a systolic BP of 90 – 100 mmHg with 500ml boluses-max of 2000ml and/or if the assessment indicates any of the following: a. Hemodynamic Instability-Place patient supine with legs elevated b. Concurrent respiratory compromise c. Glasgow Coma Score of < than or equal to 13 d. Significant Hemorrhage e. Suspected Ectopic Pregnancy f. Heart rate > 120
Pain Management	Refer to Pain Management Protocol 554.44

Clinical PEARLS:

- Consider 12 lead acquisition

POLICY: 554.46
TITLE: Nausea or Vomiting

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NAUSEA OR VOMITING

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

II. PURPOSE
To serve as the treatment standard for EMR's EMT's and Paramedics in treating patients.

III. PROTOCOL
Nausea or Vomiting may be due to a viral illness (such as gastroenteritis), motion sickness brought on by vehicle movement, or medication side effects. However, it is important to remember that more serious medical conditions also produce nausea or vomiting such as stroke, head injuries, toxic ingestions, bowel obstruction, appendicitis and acute coronary syndrome. Generally, benign causes of nausea or vomiting do not have any associated pain complaints. Likewise, pain or alterations in level of consciousness with associated nausea or vomiting tend to have more serious etiologies.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Suction	Be prepared to suction the airway if indicated
EMT STANDING ORDERS	
Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain glucose level
PARAMEDIC STANDING ORDERS	
Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat heart rhythm as appropriate

Consider IV Access	For prolonged history of vomiting with exam findings suggesting dehydration (dry mucous membranes, tachycardia, hypotension, poor skin turgor, delayed capillary refill), administer 500ml normal saline bolus. Recheck vitals. May repeat x1
CONSIDER ONDANSETRON	**For severe nausea or persistent vomiting:** Administer 4mg IV/IM. May repeat every 10 minutes to a maximum of 12mg. **Note: administer IV dose over 1 minute (slow IV push). Ondansetron is contraindicated in patients with hypersensitivities to Ondansetron or similar medications such as Dolasetron (Anzemet®), Granisetron (Kytril®), Palonosetron (Aloixi®)**

Clinical PEARLS:

- Rapid administration of Ondansetron has been associated with increased side effects, most notably syncope. Ondansetron must be administered SLOWLY over 1 minute.
- Other rare side effects of Ondansetron include headache, dizziness, tachycardia, sedation, or hypotension.
- Ondansetron is SAFE for use in pregnancy or breast-feeding mothers.
- Note color of emesis
- 12 lead acquisition if cardiac is suspected

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.47
TITLE: Ketamine for Analgesic Use

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

KETAMINE FOR ANALGESIC USE

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

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

III. PROTOCOL: Every patient deserves to have his or her pain managed. Consider reassurance, position of comfort, ice and gentle transport as part of pain management. Privacy and separation from parents may benefit adolescents. Do not attempt to completely relieve the patient's pain, but treat aggressively enough to make it bearable.

- **If a Non-Transport ALS first response provider starts the administration of Ketamine, that provider must accompany the patient to the hospital and maintain primary care of the patient UNLESS handing that patient off to another paramedic that has received Ketamine training.**

Eligibility Criteria:

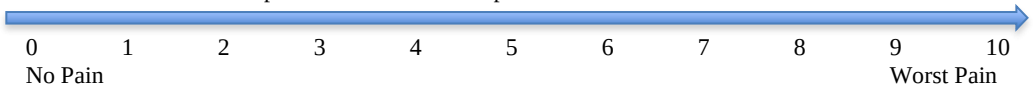
1. **15 years of age or older**
2. **GCS of 15**
3. **Acute Traumatic or Burn injury**

Exclusion Criteria

1. **Known/Suspected pregnancy**
2. **Allergy to Ketamine**

STANDING ORDERS	
GENERAL ASSESSMENT	CAB
OXYGEN	Oxygen delivery as appropriate to maintain O_2 saturation 92 – 98%
MONITOR	
PULSE OXIMETRY	
IV/IO ACCESS	TKO
ASSESS PAIN	Utilize pain scale found below. Note and document initial pain score.
KETAMINE	If pain score is 5 or above, mix 0.3 mg/kg Ketamine (max dose = 30mg) in 50 - 100cc NSS or D5W, and administer IV/IO drip over at least 5 minutes.
PLACE BAND	Place "Ketamine Administered" wrist band on patient.
REASSESS	Assess and document pain score every 5 minutes for duration of transport.
KETAMINE	If after 15 minutes or more, the pain score is 5 or higher, may administer a second dose of 0.3 mg/kg Ketamine (max dose = 30mg) in 50 - 100cc NSS or D5W IV/IO drip over at least 5 minutes.

This is the official pain scale to be used in patient assessment and documented on the PCR.



Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.51
TITLE: Poisoning/Overdose

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

POISONING/OVERDOSE

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

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

III. PROTOCOL
Be careful not to contaminate yourself and others, remove contaminated clothing, refer to Emergency Response Guide and bring in the container or label.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Suction	Be prepared to suction the airway
EMT STANDING ORDERS	
Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain blood glucose level if patient displays ALOC
Naloxone	If respirations are <10/min or systolic BP<90, give 2mg IM or IN. May repeat once in 3-5 minutes if high suspicion of narcotic overdose
PARAMEDIC STANDING ORDERS	
Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat heart rhythm as appropriate

IV/IO Access	If systolic BP is < 90mmHg, give 500ml boluses until systolic BP is 90-100mmHg. Reassess patient after each bolus. Max fluid 2000ml
	NARCOTICS/OPIODS-SEDATIVES
Naloxone	Only if respirations are < 10/min or systolic BP is < 90mmHg, give 2mg IV/IO/IM/IN. May repeat ONCE in 3-5 minutes if high suspicion of narcotic overdose.
	TRICYCLIC ANTIDEPRESSANTS
Sodium Bicarbonate	1mEq/kg IV/IO for: a. GCS < 15 b. HR > 100 c. Systolic BP < 90mmHg d. QRS widening > 0.12 e. High suspicion of tricyclic ingestion Repeat 0.5mEq/kg IV/IO every 5 minutes for persistent signs and symptoms.
	BETA BLOCKER OVERDOSE
Atropine	1mg IV/IO if BP < 90mmHg AND HR < 50/min with serious signs and symptoms. May repeat once in 5 mins.
Glucagon	1mg IM for serious signs and symptoms of Beta Blocker overdose only.
	CALCIUM CHANNEL BLOCKER OVERDOSE
Calcium Chloride	If Calcium Channel Blocker ingestion is suspected, give 100mg for BP < 90mmHg AND HR < 50/min AND serious signs and symptoms. May repeat in 5 minutes.
Atropine	1mg IV/IO if BP < 90mmHg AND HR < 50/min with serious signs and symptoms. May repeat once in 5 mins.
	CAUSTICS/CORROSIVES/PETROLEUM DISTILLATES
Remove Agent. If agent is dry, brush off then flush with copious amounts of water. If agent is liquid, flush with copious amounts of water. If eyes are contaminated, flush with water for a minimum of 20 minutes. **Do not induce vomiting or give Activated Charcoal**	
	ORGANOPHOSPHATES
Atropine	2mg slow IV/IO or IM. Repeat every 3 minutes as needed to control secretions, bronchorrhea, and dysrhythmias Signs and symptoms include- Salivation, Lacrimation, **U**rination, **D**efecation, **G**I upset, **E**mesis, and **M**uscle twitching
	AMPHETAMINE OR COCAINE INTOXICATION WITH ACUTE AGITATION
Midazolam	2mg IV/IO. Titrate 1mg increments to control agitation or psychosis (max dose of 6mg). If unable to establish IV access (after one attempt), give 5mg IM/IN. May repeat IM/IN dose once in 10 minutes if uncontrollable behavior continues.

Clinical PEARLS:

- Contact Base Hospital if any questions or if additional therapy/treatment is required. Any Poison Control Center consultation must be coordinated with Base Hospital.
- If Law enforcement administers Naloxone prior to arrival, EMS may administer additional Naloxone if suspected narcotic overdose
- ETCO2 monitoring required for administration of Midazolam if tolerated by patient

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE 7/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 7/01/2016
PAGE: 1 of 1

DYSTONIC REACTION TO PHENOTHIAZINE DRUGS

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

II. PURPOSE: To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.

III. PROTOCOL: Phenothiazines are prescribed for their antiemetic and anti-cholernergic properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine) and promethazine (Phenergan)

A non-phenothiazine medication that can cause dystonic reactions is haloperidol (Haldol).

Symptoms might include restlessness; muscle spasms of the neck; jaw and back' movement of eyeballs (oculogyric crisis); frightened; facial grimace; protruding tongue, back arching (opisthotonus).

Phenothiazines are prescribed for their antiemetic and tranquilizing properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine) and promethazine (Phenergan and Atarax).

NOTE: Phenothiazine reactions may occur at normal dosing levels. Activated charcoal is not necessary.

STANDING ORDERS	
ASSESS	CAB
OXYGEN:	Oxygen delivery as appropriate
MONITOR:	Treat rhythm as appropriate.
IV/IO ACCESS:	TKO
DIPHENHYDRAMINE:	25mg IV/IO push. May repeat 25mg ONCE if needed. May administer 25mg IM if IV access not promptly available.
BASE PHYSICIAN ORDERS	
RELEASE-AT-SCENE	Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES:

REVIEW DATE: 4/2021
PAGE: 1 OF 1

NERVE AGENT EXPOSURE

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

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

III. PROTOCOL: "Nerve Agent" means an extremely toxic organophosphate-type chemical, including GA (Tabun), GB (Sarin), GD (Soman), GF (Cyclosarin) and VX which attack the nervous system and interfere with chemicals that control nerves, muscles and glands. They are odorless, invisible and can be inhaled, absorbed through the skin or swallowed. This protocol applies to large-scale organophosphate poisonings. *General treatment centers on terminating the exposure, patient decontamination, Chempack deployment, airway support and pharmacological treatment.*

STANDING ORDERS

DECONTAMINATE	Decontaminate prior to patient contact
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway. Refer to General Procedures Protocol 554.00
POSITIONING	Position patient left lateral/recovery position
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Rate as indicated. If systolic BP is <90mmHg, give 250cc boluses until systolic BP is 90-100mmHg. Reassess patient after each bolus.
DETERMINE LEVEL OF EXPOSURE	Mild: Rhinorrhea, Chest Tightness, Dyspnea, Bronchospasm Moderate: SLUDGEM Severe: SLUDGEM, Severe Dyspnea, Seizures, Agitation, Drowsiness, Coma, Staggering

Exposure/Symptoms	**Treatment**	
	Atropine	**Pralidoxime (2-Pam)**
Asymptomatic	None (monitor patient)	None (monitor patient)
Mild	**Adult:** 1 Auto Injector (2mg) IM. **Pedi**: **DO NOT Administer**	**Adult:** One (1) Auto-injector (600 mg) IM ***IF*** Signs and Symptoms do not resolve 5 minutes after Atropine administration. **Pedi**: **DO NOT Administer**
Moderate	**Adult:** 2 Auto-injectors (4mg) IM. **Pedi**: **DO NOT Administer**	**Adult:** 1 Auto-injector (600 mg) IM, may repeat 1x in 5-10 min. as needed. **Peds: DO NOT Administer**
Severe	**Adult:** 3 Auto-injectors (6 mg) IM. **Peds:** 0.02mg/kg IV/IO/IM, minimum dose 0.1mg, repeat as needed	**Adult:** 3 Auto-injectors (1.8 Gms) IM. *Do NOT repeat.* **Peds:** 20-40mg/kg IV/IO/IM, max 1 gram IM, repeat as needed

VALIUM (For Seizures)	**Adult:** 2.5-10mg slow IV/IO push to control seizures, may repeat once for recurrent seizures. Max dose 20mg. **Pedi:** 0.1-0.3 mg/kg slow IV/IO, may repeat at 0.05-0.1mg/kg IV/IO. Max dose 10mg.

POLICY: 554.61
TITLE: Envenomation

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ENVENOMATION

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

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO
IDENTIFY CAUSE	**Bee/Wasp/Yellow Jacket/Fire Ant sting** Remove stinger. Refer to Allergic Reaction Policy 554.43 **Spider bite - Scorpion sting - Centipede sting** No specific treatment. **Snake envenomation** Avoid movement of the affected extremity, keeping extremity at heart level. Splinting is unnecessary. **Do not apply ice or constricting band**. Monitor distal pulses. Circle any swelling around bite marks with a pen and note time. Measure the circumference of the extremity proximal to the bite and note time. **Do not bring the snake to the emergency department!**
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44

POLICY: 554.62
TITLE: Hypothermia

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HYPOTHERMIA

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

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

III. PROTOCOL
Patients with mild hypothermia will not be comatose due to that illness. They will often be mildly confused or sleepy. Mental status may be more depressed if intoxication, head injury, shock, ketoacidosis or stroke has caused secondary mild hypothermia.

STANDING ORDERS	
MILD HYPOTHERMIA **Verbally responsive or GCS less than or equal to 12**	
ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry blankets.
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Warm IV fluid, rate as indicated.
	CONSIDER
ACCUCHECK	Test for glucose
DEXTROSE	25 gms IV/IO push – if blood glucose less than 60 mg/dl. May repeat once. Recheck blood sugar 5 minutes after each dose. Give oral glucose solution to patients who are awake and have an intact gag reflex.
GLUCAGON	1 unit IM – if no IV/IO access immediately available and blood glucose less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	2 mg IN (IV/IO/IM if IN not available), only if respiratory rate less than 10/minute or systolic BP less than 90mmHg AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, or history of narcotic use. May repeat ONCE in 3 minutes if inadequate response **Narcan must be administered before intubating a symptomatic narcotic overdose**

STANDING ORDERS CONTINUED

SEVERE HYPOTHERMIA
Verbally responsive or GCS greater than or equal to 12

ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry blankets. ***Sudden movement to patient may cause life-threatening arrhythmia***
SECURE AIRWAY	Intubate **only if absolutely necessary.** Spontaneous ventilations of 4-6 per minute may be adequate. Use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Observe rhythm and pulses for one minute - if organized rhythm present, **move gently**. Treat dysrhythmias as appropriate. Severe bradycardia with pulses requires no antiarrhythmic therapy.
IV/IO ACCESS	Warm IV fluid, rate as indicated. Most severely hypothermic patients are volume-depleted.
	CONSIDER
ACCUCHECK	Test for glucose
DEXTROSE	25 gms IV/IO push – if blood glucose less than 60 mg/dl. May repeat once. Recheck Blood Sugar in 5 minutes after each dose. Give oral glucose solution to patients who are awake and have an intact gag reflex.
GLUCAGON	1 unit IM – if no IV/IO access immediately available and blood glucose less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	2 mg IN (IV/IM/IO if IN not available), only if respiratory rate less than 10/minute or systolic BP less than 90mmHg AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, or history of narcotic use. May repeat ONCE in 3 minutes if inadequate response **Narcan must be administered before intubating a symptomatic narcotic overdose.**
CARDIAC ARREST	Give only one dose of each drug during cardiac arrest, but continue normal CPR and defibrillation attempts.

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE 7/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 7/01/2016
PAGE: 1 of 1

FROSTBITE

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

II. PURPOSE: To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate
EVALUATE WARMING MEASURES	Evaluate all exposed at-risk body parts. Move patient to warm environment and wrap affected extremity with thick, un-warmed blankets or clothing. **Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.**
IV ACCESS	TKO
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 7/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 7/2016

HEAT ILLNESS

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

II. PURPOSE**:** To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.

III. PROTOCOL:

Heat Exhaustion: Muscle cramping, fatigue, nausea, headache, normal or slightly elevated body temperature. Syncope or dizziness is almost universal.

Heat Stroke: Persistently altered level of consciousness and elevated body temperature (usually greater than 104% F or 40 C), tachycardia and hypotension. Sweating is variable.

STANDING ORDERS	
HEAT EXHAUSTION	
ASSESS	CAB
COOLING MEASURES	Place patient in a cool environment.
OXYGEN	Oxygen delivery as appropriate**.**
IV ACCESS TKO	If systolic BP less than 90 mmHg, give 250 ml fluid boluses until systolic BP 90-100. Reassess the patient after each bolus.
HEAT STROKE	
ASSESS	CAB
COOLING MEASURES	Remove heavy or insulating clothing and splash patient with water. Place ice packs on head, neck and in axilla and inguinal areas. Promote cooling by fanning. Use all available cooling measures.
OXYGEN	Oxygen delivery as appropriate**.**
IV/IO ACCESS	Two 14-16 gauge. If systolic BP less than 90 mmHg, give 250 ml fluid boluses until systolic BP 90-100. Reassess the patient after each bolus.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	25 gm IV/IO push - if blood glucose is less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
GLUCAGON	1 mg IM - if blood glucose is less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
MIDAZOLAM	If seizing 2mg initial dose IV/IO push. Titrate in 1mg increments for seizure control (maximum dose: 6mg). If unable to establish IV/IO after one attempt, give 5mg IM. May repeat once in 10 minutes if seizures continue.

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Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE 7/01/2011
REVISED:
REVIEW DATE: 7/01/2016

CHILDBIRTH

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

II. DEFNINITIONS: Designated Hospital may include any of the following facilities:

- Sutter-Roseville Medical Center, Roseville
- U.C. Davis Medical Center, Davis
- Madera Children's, Madera
- Regional Medical Center, Fresno
- San Joaquin General, Stockton
- Washoe Medical Center, Reno NV
- Doctors Medical Center, Modesto*
- Memorial Medical Center, Modesto*

*These facilities are considered equidistant for purposes of determining closest facility located in Modesto.

III. PURPOSE**:** To serve as a patient treatment standard for EMT-1s and Paramedics within their scope of practice.

IV. PROTOCOL:

STANDING ORDERS	
ALL DELIVERIES	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate
ROUTINE DELIVERY	
TRANSPORT	Transport with mother placed on left side.
DELIVER NEWBORN	As head is delivered **clear airway if needed**,. Use hand on head to prevent explosive delivery. If cord is wrapped around neck and cannot be slipped over the newborn's head, double clamp and cut between clamps. Complete delivery of newborn's body. Dry newborn and keep warm. Place newborn on mother's abdomen or breast. Double clamp and cut cord between clamps 6 – 8 inches from newborn.
ASSESS NEWBORN	Refer to Newborn Resuscitation Policy 555.10
FOLLOWING DELIVERY OF PLACENTA	Massage Fundus
BREECH PRESENTATION	
TRANSPORT	Code 3 while maintaining airway for newborn to a Designated Hospital.
CONSULT BASE PHYSICIAN	
DELIVER NEWBORN	For a buttocks presentation, allow newborn to deliver to waist. Support the limbs and torso. Use hand on torso to prevent explosive delivery. When legs and buttocks are delivered, the head can be assisted out. If the head does not deliver rapidly, insert gloved hand into vagina, palm towards baby's face and cord between fingers to create an airway.

STANDING ORDERS CONTINUED	
PROLAPSED CORD	
TRANSPORT	Code 3 to a Designated Hospital.
POSITION	Place the mother supine in knee-chest position, face down.
PROTECT CORD	Insert gloved hand into vagina and gently push the presenting part off the cord. Cover exposed portion of cord with saline-soaked gauze. Do not attempt to push cord back into vagina.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 4/15/2016
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

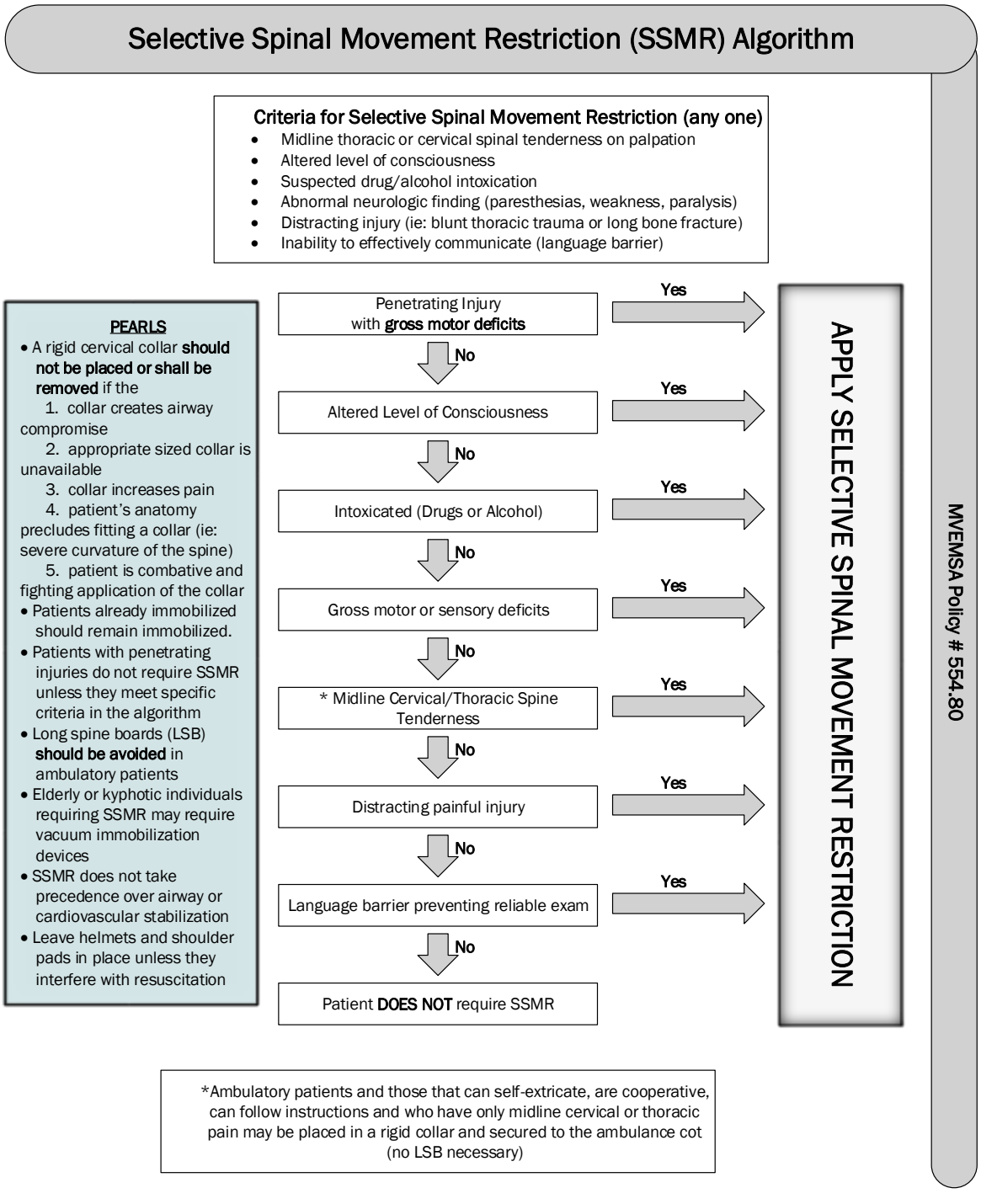
REVIEW DATE: 4/2021

SELECTIVE SPINAL MOVEMENT RESTRICTION (SSMR)

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

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

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



POLICY: 554.81
TITLE: Burns

EFFECTIVE: 04/10/19
REVIEW: 04/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Burns

I. AUTHORITY

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

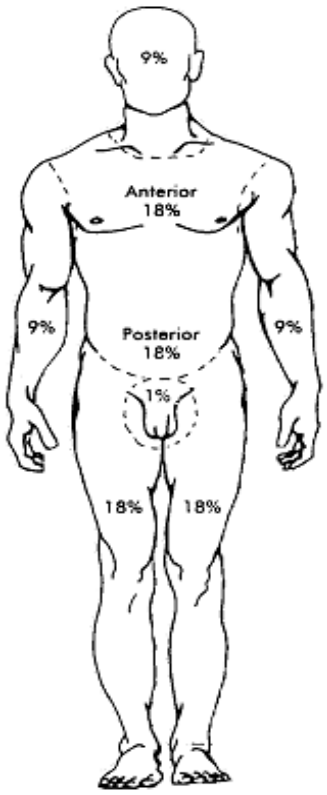
II PURPOSE

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

III. PROTOCOL

STANDING ORDERS	
MOVE PATIENT	To a safe environment
ASSESS	CAB
COOLING PROCESS	Tar Burns: Cool with water and transport. Do not attempt to remove tar. Thermal Burns: Cool with water for up to 5 minutes to stop the burning process.
OXYGEN	Oxygen delivery as appropriate
SECURE AIRWAY/ INTUBATE	Consider EARLY intubation if ineffective ventilation/oxygenation, or if patient is unconscious. Otherwise, use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Protocol 554.00
IV/IO ACCESS	**Superficial Burns:** TKO **Partial and full-thickness burns:** 0.5 ml times patient weight in kg times % of burn = IV/IO fluid per hour. If systolic BP less than 90mmHg, give 250 ml boluses until systolic BP 90-100. Reassess patient after each bolus. **Major Burns:** Two 14-16 gauge IV/IO in patients with major burns (greater than 9%) TKO. If systolic BP less than 90mmHg, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus. IV site in order of preference: 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity

MONITOR	Treat rhythm as appropriate.
DRESS BURNS	Cover with dry dressing and keep patient warm.
PAIN MANAGEMANT	Refer to Pain Management Protocol 554.44
TRANSPORT	To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.



Adult Body Part	% of Total Body Surface
Arm (shoulder to fingertips)	9 (x2)
Head/Neck	9
Groin	1
Leg	18 (x2)
Anterior trunk	18
Posterior trunk	18

The patient's palm (hand including fingers) is about 0.9% of the patient's body surface area.

POLICY: 554.82
TITLE: Traumatic Shock

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Traumatic Shock

I. AUTHORITY

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

II PURPOSE

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY/INTUBATE	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
OXYGEN	Oxygen delivery as appropriate.
SPINE IMMOBILIZATION	If indicated, refer to General Procedures Protocol 554.00
UNCONTROLLED HEMORRHAGE	Place a tourniquet for uncontrolled extremity hemorrhage. Pack truncal penetrating injuries with Hemostatic dressings if applicable
POSITION	Do not use Trendelenberg (feet elevated) position. If patient is pregnant place patient on left side, or tilt spine board 30° to left.
IV/IO ACCESS	Two 14-16 gauge IV/IO, wide-open until systolic BP 80 mmHg or 2L infused, then TKO. If systolic BP remains less than 80mmHg, give 250 ml boluses until systolic BP reaches 80 mmHg. Reassess the patient after each bolus.
TENSION PNEUMOTHORAX	Refer to Tension Pneumothorax Protocol 554.23

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.83
TITLE: Traumatic Cardiac Arrest

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Traumatic Cardiac Arrest

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

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
CPR	Do not delay transport even if CPR has to be interrupted. Minimize interruptions in compressions as much as possible.
MONITOR	For V-Fib or Pulseless V-Tach: defibrillate once at 360J or equivalent biphasic energy setting. Complete this protocol before referring to cardiac protocols.
SECURE AIRWAY/ INTUBATE	Use the simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
OXYGEN	Ventilate with bag-valve or approved ventilator and 100% oxygen.
UNCONTROLLED HEMORRHAGE	Pack truncal penetrating injuries with Hemostatic dressings if applicable. Place a tourniquet for uncontrolled extremity hemorrhage.
SPINE IMMOBILIZATION	If indicated, refer to 554.80 Selective Spinal Movement Restriction
IV/IO ACCESS	Two 14-16 gauge, wide-open until systolic BP 80 mmHg or 2L infused, then TKO. If systolic BP remains less than 80, give 250 ml boluses until systolic BP reaches 80 mmHg. Reassess the patient after each bolus
	CONSIDER
NEEDLE THORACOSTOMY	10 or 12 gauge catheter-over-needle, minimum 3.25 inch length, inserted into affected side in the second intercostal space, mid-clavicular line. Perform on other side if no response to treatment and the tension pneumothorax physiology persists. Secure catheter.
BASE PHYSICIAN ORDERS	
DETERMINATION OF DEATH	Refer to Determination of Death Protocol 570.20

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.84
TITLE: Head-Neck-Facial Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Head-Neck-Facial Trauma

I. AUTHORITY

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

II PURPOSE

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate.
POSITION	Elevate the head of brain injured patients, if patient exhibits no signs of shock. If patient is pregnant, place patient on left side, or tilt spine board 30 degrees to left.
IV/IO ACCESS	TKO. For suspected TBI, if systolic BP is less than 80mmHg, give 250 boluses to SBP reaches 100 mmHg. Reassess patient after each bolus.
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44.
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing as appropriate.
CONSIDERATIONS	**Avulsed Tooth -** Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver."
	Eye Injuries - cover with a non-contact dressing, such as a paper cup. Do not apply direct pressure to eye and do not attempt to replace partially torn globe.
	Impaled Object - immobilize and leave in place. Remove object if it interferes with CPR, extrication, or ventilation.

POLICY: 554.85
TITLE: Chest Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Chest Trauma

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

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

III. PROTOCOL

STANDING ORDERS	
ABCs	
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
POSITION	If patient is pregnant place patient on left side, or if in spinal immobilization, tilt spine board 30 degrees to the left.
IV/IO ACCESS	TKO
DRESS WOUNDS	Use hemostatic dressing if applicable
CONSIDERATIONS	**Impaled Object** - Immobilize and leave in place. Remove object if it interferes with CPR, ventilation or extrication. **Flail Chest** -. Observe for tension pneumothorax. Consider assisted ventilation. **Penetrating Chest Injury**- Cover wound. Dress wound loosely. Use appropriate chest seal device, or tape occlusive dressing on three sides over the wound. Continuously re-evaluate patient for the development of a tension pneumothorax. **Tension Pneumothorax** - Perform needle thoracostomy or remove any occlusive dressing covering an open chest wound. Refer to the Tension Pneumothorax Protocol 554.23. **Cardiac Tamponade** - If systolic BP less than 80mmHg, administer 250 cc fluid boluses until systolic BP reaches 80 mmHg. Reassess the patient after each bolus. Refer to the Traumatic Shock Protocol 554.82. **Cardiac Contusion** - Monitor for dysrhythmias. Refer to Cardiac Protocols.
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 544.44

POLICY: 554.86
TITLE: Abdominal Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Abdominal Trauma

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

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable Beyond BLS airway managementrefer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated, refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
POSITION	If patient is pregnant place patient on left side, or tilt spine board 30 degrees to the left.
IV/IO ACCESS	TKO. If systolic BP less than 80mmHg, give 250 ml fluid boluses until systolic BP 80-100. Reassess the patient after each bolus.
DRESS WOUNDS	Use Hemostatic dressings if applicable
CONSIDERATIONS	**Impaled Object** - Immobilize and leave in place. Remove object only if it interferes with CPR, extrication, or ventilation.
	Eviscerating Trauma - Cover eviscerated organs with saline-soaked gauze. Do not attempt to replace organs into the abdominal cavity.
	Genital Injuries - Cover open genitalia wound with saline soaked gauze. If necessary apply direct pressure to control bleeding. Treat amputation the same as extremity amputation: refer to Extremity Trauma Policy 554.87
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 544.44

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.87
TITLE: Extremity Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Extremity Trauma

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

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

III. PROTOCOL

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable Beyond BLS airway managementrefer to General Procedure Protocol 554.00
SPINE IMMOBILIZATION	If indicated Refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
HEMORRHAGE CONTROL	• Control bleeding with direct pressure • Use a tourniquet if bleeding is uncontrolled • Elevate and splint injured extremity in position of comfort
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing or tourniquet as appropriate.
IV/IO ACCESS	TKO. If systolic BP is less than 80mmHg, give 250 boluses to SPB reaches 80 mmHg. Reassess patient after each bolus
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44
CONSIDERATIONS	Fracture/Dislocation – Open or closed femur fractures may be splinted with traction or cardboard splints after gentle realignment with manual traction (pain management should be administered to facilitate muscle relaxation). Check neuro-vascular status prior to and after each extremity manipulation. Splint dislocations in position found. If the extremity is pulseless, attempt to place it in normal anatomic position by gentle in-line traction. **Amputations** - If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in dry sterile gauze, then place parts in a sealed and dry container. Place container on ice, if possible.
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE 4/15/16
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021

ADULT MEDICATION CHARTS

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

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

III. PROTOCOL:

DOPAMINE DRIP CHART FOR ADULTS

FOR A CONCENTRATION OF **1600** µg of DOPAMINE PER MILLILITER SOLUTION
Two 5 ml ampules of Dopamine (200 mg of dopamine per ampule) mixed in 250 ml of NS.

Body Weight	**kg**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**105**	**110**
	lbs	**110**	**121**	**132**	**143**	**154**	**165**	**176**	**187**	**198**	**209**	**220**	**231**	**242**
µg/min.	**10µg**	19	21	23	25	27	29	31	32	34	36	38	40	42
	15µg	29	32	34	37	40	43	46	49	52	54	57	60	63
	20µg	38	42	46	50	53	57	61	65	69	73	76	80	84

FLOW RATE IN DROPS PER MINUTE based on a microdrip calibration of 60 drops equal to 1.0 milliliter

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.89
TITLE: Tranexamic Acid (TXA) Administration

EFFECTIVE: 6/1/2020
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TRANEXAMIC ACID (TXA) ADMINISTRATION

I. AUTHORITY California Health and Safety Code, Division 2.5 EMS, Sections 1797.220 and 1797.221

II DEFINITIONS

Tranexamic Acid (TXA) is a Lysine analogue that works to inhibit the formation of plasmin, which is a molecule responsible for clot degradation. It therefore stabilizes clots and slows down bleeding. It has recently been shown in multiple studies to reduce mortality in trauma patients meeting specific physiologic criteria or who have signs of massive trauma.

III PURPOSE

To serve as a patient treatment standard for Paramedics within their scope of practice

IV. POLICY

Within 3 hours of a traumatic event, the prehospital use of TXA should be considered for all blunt or penetrating trauma to the trunk (thorax, abdomen, or back) in patients 15 years of age or older with one or more systolic blood pressure readings less than 90 mmHg.

Contraindications:

- Any patient <15 years of age
- Any patient more than 3 hours post injury
- Documented cervical cord injury with motor deficits
- Isolated traumatic brain injury
- Thromboembolic event (i.e. stroke, MI, PE, DVT) in the past 24 hours
- Traumatic arrest with greater than 5 minutes of CPR without ROSC

GENERAL ASSESMENT:	CAB
OXYGEN:	Oxygen delivery as appropriate to maintain O2 saturation 92-98%
MONITOR	
PULSE OXIMETRY	
IV/IO ACCESS	Preferably 16-18-gauge access
TXA	Administer 1 gram in 100ml of NS over 10 minutes (**DO NOT ADMINSTER IV PUSH: This will cause hypotension**) no repeat dose allowed. If IO route, deliver under pressure.
TXA BAND	Place appropriate band on patient identifying the administration of TXA
REASSESS	Assess and document vital signs every five minutes for duration of transport

Pediatric Treatment Guidelines

POLICY: 555.00
TITLE: General Pediatric

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PEDIATRIC

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

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

III. PROTOCOL:

PEDIATRIC MEASUREMENTS - VITAL SIGNS

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

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

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

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

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

Abnormal Vital Signs

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

POLICY: 555.10
TITLE: Newborn Resuscitation

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NEWBORN RESUSCITATION

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SUCTION	Open airway. Suction mouth and nasopharynx with bulb syringe
WARM	Dry and keep warm with thermal blanket or dry towel. Stimulate by drying vigorously, including the head and back. If not already performed: clamp and cut cord.
ASSESS	Evaluate breathing and heart rate. Perform APGAR score at 1 and 5 minutes after delivery if time allows. Do not delay resuscitative measures to score patient.
HEART RATE greater than 100	
ASSESS COLOR	If peripheral cyanosis is present: administer 100% oxygen via blow-by or mask.
REASSESS	Heart rate and respirations every 60 seconds while enroute.
HEART RATE 80 – 100	
OXYGEN	100% via mask.
STIMULATE	
REASSESS	If heart rate remains less than 100 after 30 seconds of oxygen and stimulation, begin assisted ventilation with 100% oxygen via bag-valve mask at 40 breaths per minute.
REASSESS	Heart rate and respirations every 60 seconds while enroute.
HEART RATE 60 – 80	
OXYGEN	Assist ventilations with 100% oxygen via bag-valve mask at 40 breaths per minute.
CPR	If no increase in heart rate following ventilations, start compressions at 120 per minute. If patient's heart rate is increasing, continue ventilations without compressions for an additional 15 - 30 seconds.
SECURE AIRWAY/ INTUBATE	If compressions and ventilations fail to increase patients heart rate. Ventilate with 100% oxygen via BVM using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider placement of an I-Gel- only if unable to establish adequate ventilation and oxygenation

	using a BVM and airway adjuncts. Refer to Policy 554.00 – General Protocols.
IV/IO	TKO
EPINEPHRINE	0.01 mg/kg of 1:10,000, if heart rate fails to increase above 80.
REASSESS	Heart rate and respirations every 60 seconds while enroute.

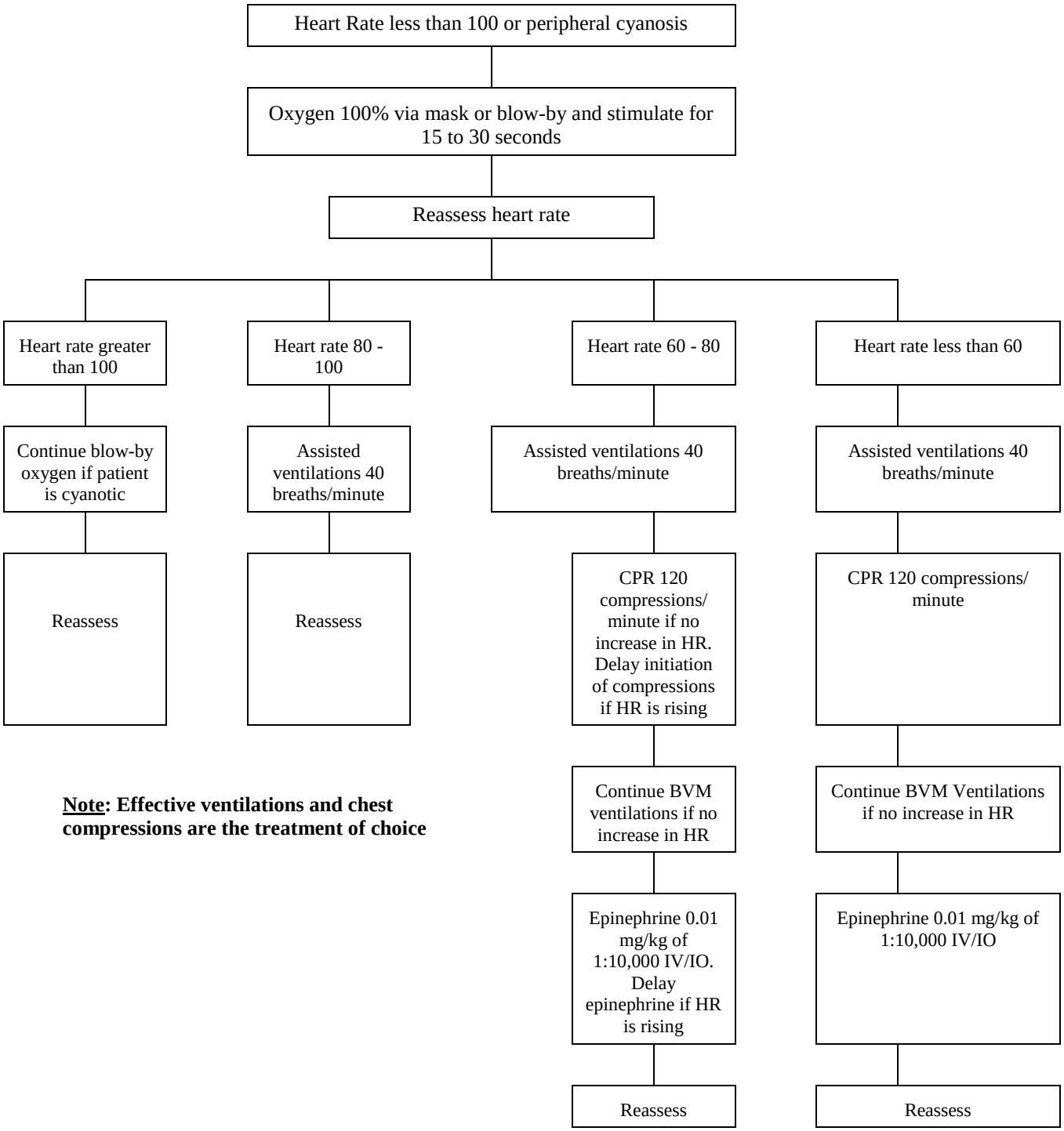
STANDING ORDERS CONTINUED

HEART RATE less than 60

OXYGEN	Assist ventilations with 100% oxygen via bag-valve mask at 40 breaths per minute.
CPR	120 compressions per minute.
SECURE AIRWAY	If compressions and ventilations fail to increase patients heart rate. Ventilate with 100% oxygen via BVM using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider placement of an I-Gel - only if unable to establish adequate ventilation and oxygenation using a BVM and airway adjuncts. Refer to Policy 554.00 – General Protocols.
IV/IO	TKO
EPINEPHRINE	0.01 mg/kg of 1:10,000 IV/IO, if heart rate fails to increase above 80.
REASSESS	Heart rate and respirations every 60 seconds while enroute.

ALGORITHM CHART FOLLOWS

NEWBORN RESUSCITATION ALGORITHM SUMMARY



<u>Note</u>: Effective ventilations and chest compressions are the treatment of choice

POLICY: 555.11
TITLE: Ventricular Fibrillation – Pulseless Ventricular Tachycardia (Pediatric)

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

VENTRICULAR FIBRILLATION – PULSELESS VENTRICULAR TACHYCARDIA

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

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

III PROTOCOL:

V-FIB: Bizarre, rapid, irregular, ineffective rhythm with electrical waveforms varying in size and shape. There is no P wave. QRS complexes absent. V-Fib may masquerade in one lead as asystole. Be sure to check at least two leads to confirm asystole.

V-TACH: Regular or slightly irregular rhythm. Heart rate about 200. A-V disassociation is present: P-waves may be seen unrelated to QRS complex. QRS complex distorted, wide (> 0.12 seconds) and bizarre. T-waves usually have opposite axis as QRS complex.

STANDING ORDERS	
ASSESS	CAB
CPR	In an un-witnessed arrest or when no CPR has been initiated by bystanders give 5 cycles of CPR (about 2 minutes). Minimize interruptions in compression as much as possible.
DEFIBRILLATE	Defibrillate at 2j/kg (or clinically equivalent biphasic energy doses). Immediately resume CPR for 5 cycles (about 2 minutes), then re-check rhythm and defibrillate at 4j/kg as appropriate. Interruption of CPR should be brief.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to General Procedures Protocol 554.00
TRANSPORT	
IV/IO ACCESS	TKO with micro-drip tubing and volume control chamber.
EPINEPHRINE	0.01 mg/kg of 1:10,000 IV/IO -. Repeat every 3 minutes.
DEFIBRILLATE	4 J/kg (or clinically equivalent biphasic energy doses). Reassess rhythm after each shock.
LIDOCAINE	1mg/kg IV/IO. Repeat once in 3 minutes if VFib/VTach persists.
DEFIBRILLATE	4 J/kg (or clinically equivalent biphasic energy doses). Repeat after each medication administered if VFib/VTach persists.
BASE PHYSICIAN ORDERS	
DECLARATION OF DEATH	After 3 doses epinephrine and 2 fluid boluses, if no reversible causes are identified.

POLICY: 555.12
TITLE: Pulseless Electrical Activity (Pediatric)

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC PULSELESS ELECTRICAL ACTIVITY

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

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

III. PROTOCOL:

The absence of a detectable pulse and the presence of some type of electrical activity other than V-Tach defines this group of arrhythmias. Many of these patients do have cardiac mechanical activity without effective cardiac output (they are in profound shock). Consider hypovolemia in these patients.

Consider Possible Causes: (Possible field treatments in parentheses)

HYPOVOLEMIA (volume infusion)
HYPOXIA (ventilation)
CARDIAC TAMPONADE
TENSION PNEUMOTHORAX (needle decompression)
HYPOTHERMIA (See Hypothermia 555.62)
PULMONARY EMBOLISM
DRUG OVERDOSE (appropriate antidote)
HYPERKALEMIA (sodium bicarb, calcium chloride)
ACIDOSIS (ventilation)
MYOCARDIAL INFARCTION

STANDING ORDERS	
ASSESS	CAB
CPR	In an un-witnessed arrest or when no CPR has been initiated by bystanders give 5 cycles of CPR (about 2 minutes). Minimize interruptions in compression as much as possible.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
CONSIDER TREATABLE CAUSES	Hypovolemia: Bolus 20ml/kg. Repeat in 5 minutes. Reassess after each bolus Tension pneumothorax: Refer to Policy 554.00 – General Protocols Hypoxia: Provide oxygen Hypothermia: Refer to Policy 555.62 – PED Hypothermia
EPINEPHRINE	0.01mg/kg of 1:10,000 IV/IO push. Repeat every 3 minutes.
IV FLUID	20 ml/kg bolus. Repeat in 5 minutes. Reassess the patient after each bolus.
BASE PHYSICIAN ORDERS	
DECLARATION OF DEATH	After 3 doses epinephrine and 2 fluid boluses, if no reversible causes are identified.

POLICY: 555.13
TITLE: Pediatric Asystole

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ASYSTOLE

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

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

III. PROTOCOL:

Asystole represents the total absence of electrical activity in the heart. There is no rhythm, although an occasional P wave or QRS may be seen. Heart rate is less than five beats per minute. Note: Asystole should be confirmed by at least two leads, since low-amplitude ventricular fibrillation can mimic asystole.

For the majority of children, asystole represents death, not a treatable arrhythmia. Look for the few patients with treatable causes.

STANDING ORDERS	
ASSESS	CAB
CPR	In an un-witnessed arrest or when no CPR has been initiated by bystanders give 5 cycles of CPR (about 2 minutes). Minimize interruptions in compression as much as possible.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
CONSIDER TREATABLE CAUSES	Hypoxia (oxygenate) Hypothermia (Rewarm. Refer to Hypothermia Protocol 555.62) Hyperkalemia (sodium bicarbonate, calcium chloride)
EPINEPHRINE	0.01 mg/kg of 1:10,000 IV/IO. Repeat every 3 minutes.
BASE PHYSICIAN ORDERS	
DECLARATION OF DEATH	After 3 doses of epinephrine, if no reversible causes are identified.

POLICY: 555.14
TITLE: Pediatric Symptomatic Bradycardia

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC SYMPTOMATIC BRADYCARDIA

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

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

III. PROTOCOL: Most bradycardias in children are due to hypoxia. Bradycardia may also be secondary to sinus node disease, increased parasympathetic tone or drug effects (e.g., digitalis, beta-blockers, or calcium antagonists), hypothermia or head injury. Heart rate is below 60 beats per minute, with associated signs/symptoms of low cardiac output. Never treat any bradycardia if the patient does not have serious symptoms.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	**NOTE:** Most bradycardias in children are due to hypoxia.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
MONITOR	
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
ASSESS	For: 1. Heart rate: less than 80 beats per minute in infants (less than 1 year); less than 60 beats per minute in children (1 - 12 years). AND 2. Signs of poor perfusion (delayed capillary refill, diminished distal pulses, cool extremities, altered level of consciousness) or respiratory distress.
CPR	If heart rate less than 80/minute in infant or less than 60/minute child.
EPINEPHRINE	0.01 mg/kg of 1:10,000 IV/IO. Repeat every 3 minutes until above heart rate target or signs of poor perfusion or respiratory distress have improved.
	CONSIDER
ATROPINE	0.02 mg/kg IV/IO. Minimum dose 0.1 mg. Maximum single dose 0.5 mg. May be repeated once in 3 minutes.

POLICY: 555.15
TITLE: Tachycardia with Pulses - Pediatric

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

TACHYCARDIA WITH PULSES - PEDIATRIC

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

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

III. PROTOCOL:

NOTE: Use standard size 3.5-cm pediatric paddles for cardioversion for children less than 10 kg. These should be placed on the anterior chest in a sternal-apical location. If pediatric paddles are not available use adult paddles placed anterior-posterior on the chest wall.

If the defibrillator does not dial down to the indicated energy level use the lowest setting available.

STANDING ORDERS		
ABC		
OXYGEN		
MONITOR		
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber	
Sinus Tachycardia	**Supraventricular Tachycardia (SVT)**	**Ventricular Tachycardia with Pulses**
QRS less than 0.08 second	QRS less than 0.08 second	QRS greater than 0.08 second
Heart Rate less than 220 BPM for ages 2 and under	Heart Rate greater than 220 BPM for ages 2 and under	Heart Rate greater than 150 beats per minute
Heart Rate less than 180 BPM for ages 2 and older	Heart Rate greater than 180 BPM for ages 2 and older	
CONSIDER	If perfusion is diminished or patient is poorly responsive: Fluid bolus 20 mg/kg IV. SYNCHRONIZED Cardioversion 1 J/kg: if no response, repeat at 2 J/kg. if no response, repeat at 4 J/kg.	
BASE PHYSICIAN ORDERS		
SVT		
VAGAL MANEUVER	Consider if child has normal perfusion. (Vagal maneuver in infants and children under 6 years old is ice water to face. In children over 6 years use Valsalva.)	
ADENOSINE	0.1 mg/kg rapid IV/IO. (Maximum dose 6 mg.) If no change, repeat 0.2 mg/kg IV/IO. (Maximum dose 12 mg.)	
V-TACH		
LIDOCAINE	1 mg/kg IV/IO. Repeat every 5 minutes to a total of 3 mg/kg.	

POLICY: 555.16
TITLE: Pediatric Airway Management

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC AIRWAY MANAGEMENT

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

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

III. PROTOCOL:

BLS & ALS

A. Perform routine ALS/BLS medical care as directed in Policy 554.00 – General Protocols.
B. The approved airway management procedure for the unconscious pediatric patient consists of the simplest method of BLS interventions to maintain oxygen saturation >94% via the following:
   1. If gag present and BVM alone insufficient, place NPA
   2. If gag is not present and BVM insufficient, place OPA
   3. If unable to ventilate with BVM and airway adjunct, may place additional (i.e. both NPA and OPA).

ALS

   4. If airway obstruction is suspected, may use Laryngoscope with blade of choice to visualize airway to facilitate removal of Foreign Body obstruction with Magill forceps.
   5. If no airway obstruction, continue ventilation using simplest method of BLS interventions to maintain oxygen saturation >94%.
   6. If unable to ventilate using BLS interventions and no obstruction:
      a) For Pediatric patients 14 years of age or younger: Place supraglottic airway and ventilate at rate of 1 ventilation every 3 seconds.
      b) Monitor capnography

POLICY: 555.21
TITLE: Pediatric Airway Obstruction

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC AIRWAY OBSTRUCTION

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

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

III. DEFINITIONS:

Partial Obstruction: Stridor, coughing forcefully, able to speak/cry, still passing some air

Complete Obstruction: Cyanosis, silent cough, unable to speak/cry, no air movement.

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

Needle Cricothyrotomy is contraindicated in pediatric patients.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
CONSIDER IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
CONSIDER CAUSE and SEVERITY	

PARTIAL OBSTRUCTION	
Foreign Body	Observe patient; supportive care.
Croup/Epiglottitis	Position of comfort. Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway.
Trauma	Suction; supportive care.
Anaphylaxis	Refer to Policy 555.42 – Pediatric Allergic Reaction.

STANDING ORDERS CONTINUED

COMPLETE OBSTRUCTION

Foreign Body	Abdominal thrusts, chest thrusts, laryngoscopy and removal with Magill Forceps.
Croup/ Epiglottitis	Position of comfort. Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless foreign body obstruction removal is required.
Trauma	Aggressive suctioning; supportive care, secure airway as appropriate. Refer to Policy 554.00 – General Protocols.
Anaphylaxis	Refer to Allergic Reaction Policy 555.42.

UNCONSCIOUS PATIENT

CPR

SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.22
TITLE: Pediatric Respiratory Arrest

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC RESPIRATORY ARREST

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
ACCUCHECK	Test for glucose. Refer to Policy 555.31 – PED ALOC, if blood sugar less than 60 mg/dL.
	CONSIDER
AIRWAY OBSTRUCTION	Refer to Policy 555.21 – Pediatric Airway Obstruction.
NALOXONE	0.1 mg/kg IV/IO/IM, if mental status and respiratory effort are depressed, the patient is not a newborn and there is a strong suspicion of opiate overdose. Maximum single dose 2 mg. May repeat once in 3 minutes if partial response to treatment.

POLICY: 555.23
TITLE: Pediatric Respiratory Distress

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC RESPIRATORY DISTRESS

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

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

III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
POSITION	Place patient in position of comfort, usually in parent's lap or arms. Minimize handling and examination to prevent crying and agitation. Avoid laying the patient down. A parent should be allowed to accompany the child to the hospital in order to ease the child's fears.
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.

EPIGLOTITIS

History of upper respiratory infection. Tends to occur in patients age 3 to 6, but some cases occur in children less than 2 years of age. Hx and PE: high fever, sore throat, and pain on swallowing, shallow breathing, dyspnea, inspiratory stridor, drooling, and a red swollen epiglottis: (**Do Not** attempt to visualize airway. If the patient is crying, the epiglottis may be visible posterior to the base of the tongue).

COMPLETE OBSTRUCTION

VENTILATE	With bag valve mask or approved ventilator and 100% oxygen. If unable to ventilate (no rise and fall of the chest), then consider visualizing the airway for a Foreign Body Obstruction, place an I-Gel if possible. Notify Emergency Department of possible surgical candidate.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.

ASTHMA - BRONCHIOLITIS - CROUP

Asthma:	Patient or family history of asthma or reactive airway disease. Age usually greater than 1 year; tachypnea; patient sitting up and leaning forward; nonproductive cough, accessory respiratory muscle usage and wheezing (wheezing may not be present if the patient has insufficient air movement).
Bronchiolitis:	Age generally less than 1 year, prominent expiratory wheezing and crackles; history of recent upper respiratory infection and fever.
Croup:	Occurs mostly at night during the fall and winter months. History: Mild cold or other infection. Age between 6 months and 4 years, harsh - barking cough, inspiratory stridor.
ALBUTEROL	3.0 ml of 0.5% solution in 15 ml saline (or 6 unit-dose vials) via nebulizer over 1 hour or until symptoms improve. Repeat as needed.

	CONSIDER
SALINE NEBULIZER	For croup patients.
	BASE PHYSICIAN ORDERS
EPINEPHRINE	0.01 mg/kg of 1:1000 IM, (max. dose 0.5 mg) for wheezing or stridor, if patient is not a neonate. May repeat once in 20 minutes.

POLICY: 555.31
TITLE: Pediatric Altered Level of Consciousness

EFFECTIVE: 6/10/20
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS

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

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

III. PROTOCOL: Characterize by a Glasgow Coma Score less than 15, mental confusion, unconsciousness, or a change from baseline.

EMR Standing Orders	
Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes and consider trauma mechanism
Oxygen Administration	Provide oxygen if appropriate
Bleeding control	Direct pressure with appropriate bandage

EMT Standing Orders	
Note	Must perform items in EMR standing orders as appropriate
Glucometer	Check blood sugar
Pulse oximetry	Report initial reading to paramedic if applicable
Glucose	Oral glucose if patient can protect airway and has a gag reflex and blood sugar <60mg/dl with signs of hypoglycemia
Naloxone	0.1mg/kg IN/IM if mental status and respiratory effort are depressed and the child is not a newborn. There MUST be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

Paramedic Standing Orders	
Note	Must perform items in EMR and EMT standing orders as appropriate
Monitor	Treat heart rhythm as appropriate
Temp	Consider sepsis for any altered pediatric with a fever

IV/IO Access	Fluid as appropriate using Micro-Drip (60gtts/min) set. Use Broselow tape for reference
Dextrose	For blood sugar <60mg/dl: D50W 1mg/kg IV/IO for patients over 2 years of age or D25W2mg/kg IV/IO for patients under 2 years of age. May repeat once
Glucagon	**0.05 mg/kg IM if blood glucose <60mg/dl and IV/IO access is not immediately available. May repeat once. Recheck blood glucose in 5 minutes.**
Naloxone	0.1mg/kg IV/IO/IN/IM if mental status and respiratory effort are depressed and the child is not a newborn. There MUST be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

Clinical PEARLS

- High index of suspicion of sepsis in a non-traumatic altered pediatric
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 4-6ml/kg drip if D25w and D50w is unavailable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 7/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 7/2016

PEDIATRIC SEIZURES

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

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

III. PROTOCOL: Status Seizures means an actively seizing child who has been seizing for more than ten (10) minutes or an actively seizing child with recurrent seizures, with no reawakening in between seizures.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose is less than 60mg/dl: D50W 1 ml/kg IV/IO for patient greater than 2 years of age or D25W 2 ml/kg IV/IO for patients less than 2 years of age. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
STATUS SEIZURES	
MIDAZOLAM	0.1 mg/kg IV/IO (maximum dose: 5 mg) OR If unable to establish IV after one attempt, give 0.2 mg/kg IM (Maximum dose: 5 mg). May repeat once in 10 minutes if seizures continue.

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.41
TITLE: Pediatric Non-Traumatic Shock

EFFECTIVE: 4/25/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC NON-TRAUMATIC SHOCK

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

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

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

Physical signs may be due to circulatory insufficiency (collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse) or sympathetic compensation (pale, cold, clammy, mottled skin, rapid respirations, anxiety). Signs of compensation may be absent in children or if taking vasoactive medications. **NOTE:** a decreased blood pressure is a late sign of shock.

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to General Procedures Protocol 554.00.
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	With micro drip tubing and volume control chamber. Give 20 ml/kg fluid boluses until Broselow tape BP target. Reassess after each bolus.
CONSIDER CAUSE	Cardiogenic - IV fluid boluses. Hypovolemia - IV fluid boluses. Hypoxia - oxygenate. Anaphylaxis - refer to Allergic Reaction Policy 555.42 Overdose - refer to Poisoning Policies 555.51-555.56 Tension pneumothorax - refer to Traumatic Shock Policy 555.82
ACCUCHECK	Test for glucose
DEXTROSE	If blood glucose less than 60mg/dl: D50W 1 ml/kg IV/IO for patient over 2 years of age or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
PUSH DOSE EPINEPHRINE	0.5-2.0mL of 10mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.

POLICY: 555.42
TITLE: Pediatric Allergic Reaction

EFFECTIVE: 6/10/20
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ALLERGIC REACTION

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
REMOVE ALLERGEN	If possible (e.g. bee stinger) and apply ice to site.
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
MILD REACTION (hives, rash, swelling)	
IV ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO/IM (maximum dose 25 mg) for severe itching.
SEVERE REACTION/ANAPHYLAXIS (wheezing, stridor, hypotension, severe respiratory depression, oral swelling, altered mental status)	
EPINEPHRINE	0.01 mg/kg of 1:1,000 IM (maximum dose 0.3 mg). (EMTs may use EITHER Epinephrine by auto-injector OR an Agency approved Epinephrine injection kit. 0.15 mg 1:1000. NO repeat doses permitted.)
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO/IM (maximum dose 50 mg) for severe itching.
ALBUTEROL	If wheezing or stridor: 3.0 ml in 15 ml saline (or 6 unit dose vials) via nebulizer over 1 hour, or until symptoms improve. Repeat as needed.
BASE PHYSICIAN ORDERS	
PUSH DOSE EPINEPHRINE	0.5 – 2.0 mL of 10 mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.

APPROVED: Signature On File In EMS Office
Executive Director

Signature On File In EMS Office
Medical Director

EFFECTIVE DATE: 4/15/2016
SUPERCEDES:

REVIEW DATE: 4/2021

PEDIATRIC PAIN MANAGEMENT

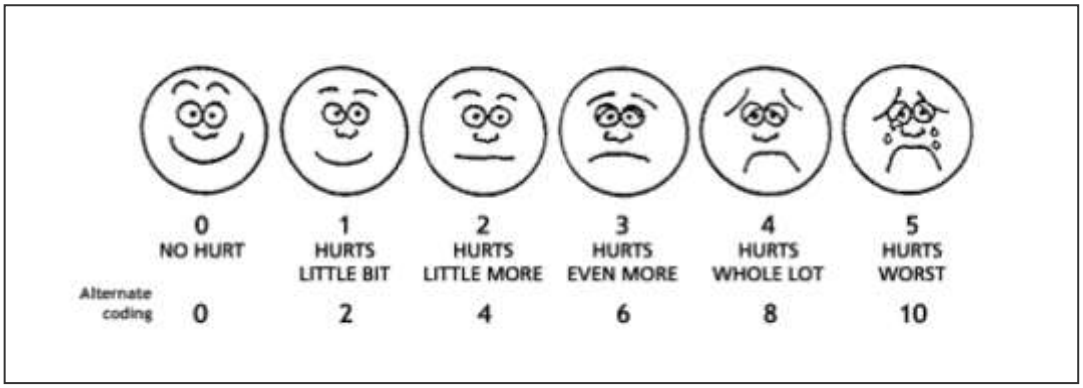
I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

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

III. PROTOCOL: Every child deserves to have their pain managed, but not necessarily treated with opioids. Consider reassurance, position of comfort, ice or heat, and gentle transport. Prevent separation anxiety in infants and children, by co-transporting parents, when possible. Maintain eye contact and be truthful about painful procedures. Acknowledge the child's fears and allow crying. Privacy and separation from parents may benefit adolescents. Maintain modesty for all children. Do not attempt to completely relieve the patient's pain, but treat aggressively enough to make it bearable.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO
MORPHINE	0.1 mg/kg **slow** IV/IO/IM push (if systolic BP above length based tape target) IV doses may be repeated once. Do not exceed 10mg total. IM doses may not be repeated.
FENTANYL	1.5 mcg/kg (maximum 75 mcg) IN. Repeat doses every 10 minutes as needed. 1 mcg/kg **slow** IV/IO push (maximum 100 mcg) (if systolic BP above length based tape target). Repeat doses of 0.5 mcg/kg slow IV/IO push (maximum 50 mcg) may be given as needed at 5 minute increments. May give 1 mcg/kg IM (maximum 100mcg) if no IV/IO access **ONCE**. Consider IN route instead. **MAXIMUM TOTAL OPIOID DOSE IS 10 MG MORPHINE EQUIVALENT (10 mg Morphine = 100 mcg Fentanyl)** **Morphine is BETTER for <u>Visceral</u> pain; Fentanyl for <u>Somatic</u> pain (try to use them this way if BOTH are carried)**
BASE PHYSICIAN ORDERS	
MORPHINE	Additional Opioid Above 10mg Morphine Equivalent per Base Physician order. Base Physician Order required to switch between Morphine and Fentanyl in the same patient.

This is the official pain scale to be used in patient assessment and documented on the PCR. Document a minimum of two pain scales (initial and on arrival at hospital).



POLICY: 555.51
TITLE: Pediatric Poisoning/Overdose

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC POISONING/OVERDOSE

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

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

III. PROTOCOL:

Contact Base Hospital if any questions or if additional therapy/treatment is required. Any Poison Control Center consultation must be coordinated with Base Hospital.

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management - refer to General Protocol 554.00.
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Rate as indicated with micro drip tubing and volume control chamber. Give 20 ml/kg fluid boluses until Broselow tape BP target. Reassess after each bolus.
NARCOTIC/OPIODS-SEDATIVES: Characterized by: respiratory depression, hypotension, stupor, coma, and pinpoint pupils. The only reasons to treat narcotic intoxication are to reverse respiratory depression and occasionally, shock.	
NALOXONE	0.1 mg/kg IV/IO/IN/SQ/IM, if mental status and respiratory effort are depressed and the child is not a neonate. Maximum single dose 2 mg. May repeat in 3 minutes if a partial response to treatment.
CYCLIC ANTIDEPRESSANT Cyclic antidepressant toxicity has a high fatality rate, even in patients who are awake and alert at the scene. The severity of an overdose can be easily underestimated. A cyclic antidepressant overdose is characterized by a rapid deterioration in mental status, rapid onset of apnea, fever, dilated pupils, flushed skin, and dry mucous membranes. These are usually associated with respiratory depression and tachycardia. Widened QRS complexes and associated ventricular arrhythmias are generally signs of a life-threatening ingestion. Types of cyclic drugs include: amitriptyline (elavil, eftrafon, triavil, limbitrol), amoxapine (asendin), desipramine (norpramin), doxepin (sinequan), imipramine (tofranil), maprotiline (ludiomil), nortriptyline (aventyl, pamelor), trimipramine (surmontil), and protriptyline (vivactyl).	
SODIUM BICARBONATE	1 mEq/kg IV/IO for any of the above signs of cyclic antidepressant intoxication. May repeat 0.5 mEq/kg slow IV/IO push every 5 minutes as needed.

CONSIDER

MIDAZOLAM	If seizing: 0.1 mg/kg IV/IO (maximum dose: 5 mg). If unable to establish IV/IO after one attempt, give 0.2 mg/kg IM (maximum dose: 5 mg). May repeat once in 10 minutes if seizures continue. Most cyclic overdose seizures are short-lived and do not require the administration of Midazolam.

STANDING ORDERS CONTINUED

CAUSTICS/CORROSIVES/PETROLEUM EXPOSURES

Alkalis: sodium hydroxide (caustic soda), drain cleaners, potassium hydroxide, ammonium hydroxide (fertilizers), lithium hydroxide (photographic chemicals, alkaline batteries), calcium hydroxide (lime).

Acids: hydrofluoric acid (which may have a delayed onset of symptoms); sulfuric acid (battery acid) and hydrochloric acid.

Oxidizers: bleach, potassium permanganate.

Petroleum Subtances: typically have an odor similar to gasoline, may cause alteration of mental status, pulmonary edema, vomiting, lung injury. Generally more viscous agents (motor oil) are less toxic.

REMOVE AGENT	Remove contaminated clothing. If agent is dry, brush off. If agent is liquid, flush with copious amounts of water. If the eyes are contaminated flush with saline for at least 20 minutes.
NOTE	Avoid the use of epinephrine in petroleum distillate ingestions unless indicated for life-threatening cardiac dysrhythmias.

IF INGESTED, DO NOT INDUCE VOMITING OR GIVE ACTIVATED CHARCOAL!

ORGANOPHOSPHATE POISONING

PROTECT YOURSELF FROM CONTAMINATION!

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

REMOVE AGENT	If agent is dry, brush off, then flush with copious amounts of water. If agent is liquid, flush with copious amounts of water. Remove and isolate contaminated clothing. All of the patient's secretions are toxic - flush off prior to transport. If possible, save container label.
ATROPINE	0.05mg/kg IV/IO/-IM. Repeat every 3 minutes as needed to control secretions, bronchorrhea and dysrhythmias.

BASE PHYSICIAN ORDERS

PUSH DOSE EPINEPHRINE	0.5 – 2.0 mL of 10 mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.52
TITLE: Pediatric Dystonic Reactions to Phenothiazine Drugs

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC DYSTONIC REACTION TO PHENOTHIAZINE DRUGS

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

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

III. PROTOCOL: History of ingestion of phenothiazine with restlessness (akathesias), muscle spasms of the neck, jaw and back, movement of eyeballs (oculogyric crisis), frightened, small pupils, facial grimace, protruding tongue, opisthotonus (back arching).

Phenothiazines are prescribed for their antiemetic and tranquilizing properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine), promethazine (Phenergan and Atarax).

Another medication that can cause dystonic reactions include: haloperidol (Haldol).

NOTE: Phenothiazine reactions may occur at normal dosing levels and administration of charcoal is not necessary.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO push (maximum dose 25 mg) or IM if IV/IO access not promptly available. May repeat if needed.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: 7/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 7/2016

PEDIATRIC ENVENOMATION

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
IDENTIFY CAUSE	
	A. Bee/Wasp/Yellow Jacket/Fire Ant sting Remove stinger. Refer to Allergic Reaction Policy 555.42
	B. Spider bite - Scorpion sting - Centipede sting No specific treatment.
	C: Snake envenomation Avoid movement of the affected extremity, keeping extremity at heart level. Splinting is unnecessary. **Do not apply ice or constricting band**. Monitor distal pulses. Circle any swelling around bite marks with a pen and note time. Measure the circumference of the extremity proximal to the bite and note time. **Do not bring the snake to the emergency department.**
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.44

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.62
TITLE: Hypothermia - Pediatric

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HYPOTHERMIA - PEDIATRIC

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

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

III. PROTOCOL: Patients with mild hypothermia will not be comatose due to that illness. They will often be mildly confused or sleepy. Mental status may be more depressed if intoxication, head injury, shock, ketoacidosis or stroke have caused secondary mild hypothermia.

STANDING ORDERS	
MILD HYPOTHERMIA (88-95 F. / 31-35 C)	
ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry, blankets.
OXYGEN	Warmed, humidified oxygen, if available.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose less than 60mg/dl: D50W 1 ml/kg IV/IO for patient over 2 years or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose solution to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM - if blood glucose less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	0.1 mg/kg IV/IO/IN/IM, only if respiratory rate less than10/minute or systolic BP below Broselow tape target, AND narcotic overdose is suspected, (i.e. pin-point pupils, track marks, drug paraphernalia, history of narcotic use, etc.) May repeat once in 3 minutes if partial response to treatment.

SEVERE HYPOTHERMIA
(less than88 F / less than 31C)

ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry, blankets.
SECURE AIRWAY	As appropriate**..** Spontaneous ventilations of 4-6 per minute may be adequate. Refer to General Procedures Protocol 554.00.
OXYGEN	Warm, humidified oxygen.
MONITOR	Observe rhythm and pulses for one minute - if organized rhythm present **move gently.** Treat dysrhythmia as appropriate.
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
	CONSIDER
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose less than 60 mg/dl: D50W 1 ml/kg IV/IO for patient over 2 yrs or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose solution to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM - if blood glucose less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	0.1 mg/kg IV/IO/IN/IM, only if respiratory rate less than10/minute or systolic BP below Broselow tape target, AND narcotic overdose is suspected, (i.e. pin-point pupils, track marks, drug paraphernalia, history of narcotic use, etc.) May repeat once in 3 minutes if partial response to treatment.
CARDIAC ARREST	Severe bradycardia with pulses requires no arrhythmic therapy. Give only one dose of each drug during cardiac arrest but continue normal CPR and defibrillation attempts.

POLICY NO: 555.63
TITLE: Frostbite (Pediatric)

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE: 71/01/2011
SUPERSEDES:
REVISED:
REVIEW DATE: 71/01/2016
PAGE: 1 OF 1

FROSTBITE - PEDIATRIC

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

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

III. PROTOCOL: Skin is white or cyanotic, numb or burning, and does not re-color with touch.

STANDING ORDERS	
ASSESS	CAB
EVALUATE	All exposed at-risk body parts.
WARMING PROCEDURES	Move patient to warm environment and wrap affected extremity with thick, unwarmed blanket or clothing. **Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.**
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43

POLICY: 555.64
TITLE: Heat Illness (Pediatric)

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

HEAT ILLNESS (PEDIATRIC)

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

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

III. PROTOCOL:

Heat Exhaustion: Muscle cramping, fatigue, nausea, headache, normal or slightly elevated body temperature. Syncope or dizziness is almost universal.

Heat Stroke: Persistently altered level of consciousness and elevated body temperature (usually greater than 104^{o} F or 40^{o} C), tachycardia and hypotension. Sweating is variable.

STANDING ORDERS	
HEAT EXHAUSTION	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
COOLING MEASURES	Place patient in a cool environment.
HEAT STROKE	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
COOLING MEASURES	Remove heavy or insulating clothing and splash patient with water. Place ice packs on head, neck and in axilla and inguinal areas. Promote cooling by fanning. Use all available cooling measures.
OXYGEN	Oxygen delivery as appropriate.
IV/IO ACCESS	Two large bore cannulas with volume control chambers. Give 20 ml/kg boluses until length based tape systolic BP target. Reassess the patient after each bolus.
	CONSIDER
ACCUCHECK	Test for glucose.
DEXTROSE	If Blood glucose is less than 60 mg/dl: D50W 1ml/kg IV/IO for patients greater than 2 years of age, or D25W 2ml/kg IV/IO who are less than 2 years of age. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60 mg/dl and no IV/IO access immediately available. Maximum dose 1 mg. May repeat once. Recheck blood glucose in 5 minutes

MIDAZOLAM	If seizing: 0.1 mg/kg IV/IO (maximum dose 5 mg.) If unable to establish IV after one attempt, give 0.2 mg/kg IM (maximum dose 5 mg.) May repeat once in 10 minutes if seizures continue.

POLICY: 555.81
TITLE: Burns - Pediatric

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

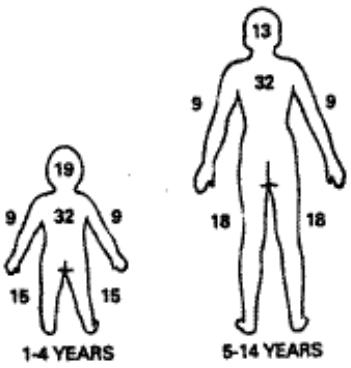
BURNS - PEDIATRIC

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

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

III. PROTOCOL:

STANDING ORDERS	
MOVE PATIENT	To a safe environment
ASSESS	CAB
COOLING PROCESS	Tar Burns: Cool with water and transport. Do not attempt to remove tar. Thermal Burns: Cool with water for up to 5 minutes to stop the burning process.
OXYGEN	Oxygen delivery as appropriate.
SECURE AIRWAY/ INTUBATE	Consider EARLY placement of an I-Gel if ineffective ventilation/oxygenation, or if patient is unconscious. Otherwise, use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
IV/IO ACCESS	**Superficial burns**: TKO. **Partial and full-thickness burns**: 0.5 ml x patient weight in kg x % burn = IV fluid per hour. If systolic BP less than length based tape target, give 20 ml/kg boluses until SBP reaches target. Reassess patient after each bolus. IV site in order of preference: 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity
MONITOR:	Treat rhythm as appropriate.
DRESS BURNS	Cover with dry dressing and keep patient warm.
PAIN MANAGEMANT	Refer to Pain Management Protocol 555.43
TRANSPORT	To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.



	Age in years			
Burn Area	**1**	**1–4**	**5–9**	**10–14**
Head	19	17	13	11
Neck	2	2	2	2
Anterior Trunk	13	13	13	13
Posterior Trunk	18	18	18	18
Genitalia	1	1	1	1
Upper Extremity (each)	9	9	9	9
Lower Extremity (each)	14.5	15.5	17.5	18.5

The patient's palm (hand minus fingers) is about 1% of the patient's body surface area.

POLICY: 555.82
TITLE: Pediatric Traumatic Shock

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC TRAUMATIC SHOCK

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
OXYGEN	Oxygen delivery as appropriate
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
CONTROL OBVIOUS BLEEDING	Consider tourniquet for uncontrolled extremity hemorrhage.
IV/IO ACCESS	Start two large-bore cannulas with volume control chambers. Give 20 ml/kg fluid boluses. Repeat x 2. Reassess the patient after each bolus administration.
DRESS & SPLINT	Consider tourniquet or hemostatic dressing for uncontrolled hemorrhage. Dress and splint as indicated.
	CONSIDER
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43
TENSION PNEUMOTHORAX	For tension pneumothorax, on affected side in second intercostal space in midclavicular line. Perform on other side if no response to treatment and tension pneumothorax physiology persists. Secure catheter to chest.
ACCUCHECK	Test for glucose.

POLICY: 555.83
TITLE: Pediatric Traumatic Cardiac Arrest

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

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC TRAUMATIC CARDIAC ARREST

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

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

III. PROTOCOL**:**

STANDING ORDERS	
ASSESS	CAB
CPR	Do not delay transport even if CPR has to be interrupted. Minimize interruptions in compressions as much as possible.
MONITOR	For V-Fib or Pulseless V-Tach refer to Pediatric Protocol 555.11
SECURE AIRWAY	Using the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
OXYGEN	Ventilate with bag-valve or approved ventilator and 100% oxygen.
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
CONTROL OBVIOUS BLEEDING	Consider tourniquet for uncontrolled extremity hemorrhage.
IV/IO ACCESS	Start two large-bore cannulas with volume control chambers. Give 20 ml/kg fluid boluses. Repeat x 2. Reassess the patient after each bolus administration.
CONSIDER	
TENSION PNEUMOTHORAX	For tension pneumothorax, on affected side in second intercostal space in midclavicular line. Perform on other side if no response to treatment and tension pneumothorax physiology persists. Secure catheter to chest.
BASE PHYSICIAN ORDERS	
DETERMINATION OF DEATH	Refer to Determination of Death policy 570.20 for obvious death criteria.

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.84
TITLE: Pediatric Head-Neck-Facial Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC HEAD – NECK – FACIAL TRAUMA

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen deliver as appropriate
POSITION	Elevate the heads of brain injured patients, if patient exhibits no signs of shock.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing as appropriate.
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43
CONSIDERATIONS	**Avulsed Tooth -** Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver."
	Eye Injuries - Cover with a non-contact dressing, such as a paper cup. Do not apply direct pressure to eye and do not attempt to replace partially torn globe.
	Impaled Object - Immobilize and leave in place. Remove object only if it interferes with CPR, extrication or ventilation.

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.85
TITLE: Pediatric Chest Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC CHEST TRAUMA

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY/INTUBATE	Using the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable..... Refer to Policy 554.00 – General Protocols.
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen delivery as appropriate
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber. If signs of shock, 20 ml/kg fluid bolus until length based tape systolic BP target. Reassess patient after each bolus.
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing as appropriate.
CONSIDERATIONS	**Impaled Object -** Immobilize and leave in place. Remove object only if it interferes with CPR, extrication, or ventilation **Flail Chest -** Stabilize chest. Observe for tension pneumothorax. Consider assisted ventilation. Penetrating Chest Injury- Cover wound. Dress wound loosely and seal injury site with chest seal or occlusive dressing taped on three sides. Continuously re-evaluate patient for tension pneumothorax. **Tension Pneumothorax -** Perform needle thoracostomy or remove any occlusive dressing on an open chest wound. Refer to the Traumatic Shock Protocol 555.82 **Cardiac Tamponade -** If systolic BP below length based tape target, give 20 ml/kg fluid boluses until systolic BP reaches target. Reassess the patient after each bolus. Refer to the Traumatic Shock Policy 555.82 **Cardiac Contusion -** Monitor for dysrhythmias. Refer to Cardiac Protocols (Policy 555.11, 555.12, 555.13, 555.14, and 555.15)
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43

POLICY: 555.86
TITLE: Pediatric Abdominal Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ABDOMINAL TRAUMA

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	
	CAB
SECURE AIRWAY/INTUBATE	Use simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
SPINE IMMOBILIZATION	If indicated, refer to General Procedures Protocol 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen delivery as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber. If signs of shock, give 20 ml/kg fluid bolus until length based tape systolic BP target. Reassess patient after each bolus.
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressings as appropriate.
CONSIDERATIONS	**Impaled Object -** Immobilize and leave in place. Remove object only if object interferes with CPR, extrication, or ventilation. **Eviscerating Trauma -** Cover eviscerated bowels and organs with saline soaked gauze. Do not attempt to replace bowels or organs into the abdominal cavity. **Genital Injuries -** Cover genitalia with saline soaked gauze. If necessary apply direct pressure to control bleeding. Treat amputation the same as extremity amputation, refer to Extremity Trauma Policy 555.87.
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 555.87
TITLE: Pediatric Extremity Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC EXTREMITY TRAUMA

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

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

III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen delivery as appropriate
HEMORRHAGE CONTROL	• Control bleeding with direct pressure • Consider tourniquet if bleeding uncontrolled • Elevate and splint injured extremity in position of comfort
DRESS & SPLINT	▪ Splint dislocations in position found. ▪ Check neurovascular status prior to and after each extremity manipulation. ▪ Control bleeding with direct pressure. ▪ Cover exposed bone with saline soaked gauze. ▪ Angulated long bone fractures may be realigned with gentle axial traction for splinting. ▪ In cases involving major multi-system trauma, consider "splinting the whole body" by strapping the patient to a back board, rather than splinting each individual extremity. ▪ Consider hemostatic dressings or tourniquet as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber. If signs of shock, give 20 ml/kg fluid bolus until Broselow Tape systolic BP target. Reassess patient after each bolus.
MORPHINE	Refer to Pain Management Protocol 555.43
CONSIDERATIONS	**Amputations -** If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in dry sterile gauze, then place in a sealed, dry container. Place container in ice, if possible.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021

PEDIATRIC MEDICATION CHART

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

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

III. PROTOCOL:

DO NOT EXCEED ADULT TOTALS
c = concentration

	Premie	**NB**	**3 Mos.**	**6 Mos.**	**1 Year**	**2 year**	**4 Year**	**6 Year**	**8 Year**	**10 Year**	**12 Year**	**13 Year**	**14 Year**
Avg. Body Length (centimeters)	0 to 53	56	63	70	77	84	92	105	120	140	150	160	166
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41	50	56
Adenosine c = 3 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg	5.0 mg	5.6 mg
Albuterol 1 unit dose (3 ml of 0.083% nebulizer solution)	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit
Atropine IV c = 0.1 mg/ml dose = 0.02 mg/kg (cardiac dose)	-	.1 mg	0.12 mg	0.14 mg	0.2 mg	0.24 mg	0.32 mg	0.4 mg	0.5 mg	0.68 mg	0.82 mg	1.0 mg	1.12 mg
Dextrose (D50W diluted to D25W) dose = 2 ml/kg	2 - 5 ml	5 - 8 ml	12 ml	14 ml	20 ml	24 ml	-	-	-	-	-	-	-
Dextrose (D50W) dose = 1 ml/kg	-	-	-	-	-	-	16 ml	20 ml	25 ml	34 ml	41 ml	50 ml	50 ml
Fentanyl IN c = 50 mcg/ml dose = 1.5 mcg/kg	3.75 mcg	3.75 - 6 mcg	9 mcg	10.5 mcg	15 mcg	18 mcg	24 mcg	30 mcg	37.5 mcg	51 mcg	61.5 mcg	75 mcg	84 mcg
Fentanyl IM/IV/IO c = 50 mcg/ml dose = 1 mcg/kg	2.5 mcg	2.5 - 4 mcg	6 mcg	7 mcg	10 mcg	12 mcg	16 mcg	20 mcg	25 mcg	34 mcg	41 mcg	50 mcg	56 mcg
Midazolam IV c = 5 mg/ml dose = 0.1 mg/kg	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg
Diphenhydramine c = 10 mg/ml dose = 1 mg/kg	1 - 2.5 mg	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg	50 mg	50 mg

	Premie	**NB**	**3 Mos.**	**6 Mos.**	**1 Year**	**2 year**	**4 Year**	**6 Year**	**8 Year**	**10 Year**	**12 Year**	**13 Year**	**14 Year**
Avg. Body Length (centimeters)	0 to 53	56	63	70	77	84	92	105	120	140	150	160	166
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41	50	56
Dopamine	FOR A CONCENTRATION OF **800** µg of DOPAMINE PER MILLILITER SOLUTION: One 5 ml ampule of Dopamine (200 mg of dopamine per ampule) mixed in 250 ml of NS												
10µg IV/IO	1	3	4	5	7	9	12	15	19	25	31	37	42
15µg IV/IO	2	4	7	8	11	13	18	22	28	38	46	56	63
20µg IV/IO	3	6	9	10	15	18	24	30	37	51	61	75	84
Epinephrine **1:10,000** IV/IO dose = 0.01 mg/kg	0.01 - 0.025 mg	0.025 - .04 mg	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg	0.5 mg	0.56 mg
Epinephrine 1:1000 SQ dose = 0.01 mg/kg	-	-	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg	0.5 mg	0.56 mg
Fluid Challenge dose = 20 ml/kg	20 – 50ml	50 – 80ml	120 ml	140 ml	200 ml	240 ml	320 ml	400 ml	500 ml	680 ml	820 ml	1000 ml	1000 ml
Glucagon c = 1 mg/ml or 1 unit/ml dose = 0.05 mg/kg (up to 1 mg)	0.3 mg	0.3 mg	0.3 mg	0.35 mg	0.5 mg	0.6 mg	0.8 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg
Lidocaine IV c = 20 mg/ml dose = 1 mg/kg	-	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg	50 mg	56 mg
Morphine c = 10 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg	5 mg	5.6 mg
Naloxone c = 1 mg/ml dose = 0.1 mg/kg (up to 2 mg)	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg
Sodium Bicarbonate c = 1 mEq/ml dose = 1 mEq/kg	1 - 2.5 mEq	2.5 - 4 mEq	6 mEq	7 mEq	10 mEq	12 mEq	16 mEq	20 mEq	25 mEq	34 mEq	41 mEq	50 mEq	50 mEq

Miscellaneous Policies

POLICY: 236.00
TITLE: EMT Scope of Practice

EFFECTIVE: 10/9/19

REVIEW: 10/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMT SCOPE OF PRACTICE

I. AUTHORITY

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

II. DEFINITIONS

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

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

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

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

III PURPOSE

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

IV. POLICY

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

A. Evaluate the ill and injured.

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

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

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

E. Administer oxygen.

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

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

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

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

J. Perform finger stick blood glucose testing

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

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

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

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

O. Perform automated external defibrillation

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

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

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

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

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

1. Nasogastric Tubes

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

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

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

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

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

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

    b. Any dressing drainage shall be noted and charted.

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

3. Foley Catheters

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

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

4. Tracheostomy Tubes

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

appropriate fashion.

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

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

POLICY: 256.00
TITLE: Emergency Medical Technician-Paramedic Scope of Practice

EFFECTIVE: 12/12/18
REVIEW: 12/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC SCOPE OF PRACTICE

I. AUTHORITY

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

II DEFINITIONS

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

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

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

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

III PURPOSE

To define the Emergency Medical Technician-Paramedic scope of practice approved for use within the Mountain-Valley EMS Agency member counties.

IV. POLICY

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

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

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

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

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

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

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

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

7. Institute intraosseous (IO) needles or catheters.

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

9. Obtain venous blood samples.

10. Use glucose-measuring device.

11. Utilize Valsalva's maneuver.

12. Perform percutaneous needle cricothyrotomy.

13. Perform needle thoracostomy.

14. Monitor thoracostomy tubes.

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

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

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

    a. 10% 25% and 50% Dextrose

    b. Activated Charcoal

    c. Adenosine

    d. Aerosolized or Nebulized beta-2 specific bronchodilators;

    e. Amiodarone

    f. Aspirin

    g. Atropine Sulfate

    h. Calcium Chloride

    i. Diazepam

    j. Diphenhydramine Hydrochloride

    k. Dopamine Hydrochloride

l. Epinephrine
m. Fentanyl
n. Glucagon
o. Ipratropium bromide
p. Lorazepam
q. Midazolam
r. Lidocaine Hydrochloride
s. Magnesium sulfate
t. Morphine Sulfate
u. Naloxone Hydrochloride
v. Nitroglycerine Preparation
w. Ondansetron
x. Pralidoxime Chloride
y. Sodium Bicarbonate

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

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

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

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

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

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

POLICY: 412.20
TITLE: EMS Transfer of Patient Care

EFFECTIVE: 11/01/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

EMS TRANSFER OF PATIENT CARE

I. AUTHORITY

Division 2.5, Health and Safety Code, Section 1797.220

II. DEFINITIONS

A. **Primary Paramedic** means the first Paramedic that makes patient contact at the scene of an emergency and has the lead responsibility to provide patient assessment and patient care until such responsibility is transferred to another Paramedic or EMT or Flight Nurse.

B. **Paramedic** means a currently licensed and accredited on-duty paramedic.

C. **Flight Nurse** means a Registered Nurse functioning as a member of an air ambulance crew.

D. **EMT** means a state certified Emergency Medical Technician

E. **Air Ambulance** - Means any rotor or fixed wing aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants certified in advanced life support.

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

G. **Basic Life Support Ambulance**: An emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III. PURPOSE

To ensure that a mechanism exists for appropriate transfer of patient care between Paramedics, EMTs, Flight Nurses, and Rescue Aircraft personnel.

IV. POLICY

A. The Primary Paramedic shall provide other assisting Paramedics, Flight Nurses, EMT's or Rescue Aircraft personnel who arrive on scene with all appropriate patient care information.

B. All Paramedics and Flight Nurses on scene have a duty to provide the Primary Paramedic with recommendations, based upon Mountain-Valley EMS Agency treatment policies, and patient care assistance to ensure the best possible patient care as logistics permit and circumstances require.

C. Paramedics are authorized to transfer the role of Primary Paramedic to another Paramedic, EMT, Flight Nurse, or Rescue Aircraft personnel when patient condition permits.

D. A Paramedic may transfer patient care to Rescue Aircraft personnel under the following conditions:

1. An air ambulance is not readily available.

2. It is determined that rapid transport is a prime therapeutic intervention for the patient.

3. If Rescue Aircraft personnel are qualified at less than the Paramedic level, Base Hospital contact shall be made to determine whether or not the Rescue Aircraft will transport the patient.

4. If Base Hospital contact cannot be made, the Incident Commander in concert with the highest medically qualified person on scene, will decide whether the Rescue Aircraft will transport the patient.

E. In systems that are approved by the Agency to use a BLS tiered response, a Paramedic may transfer patient care to a Basic Life Support Ambulance staffed with two (2) EMTs when the following conditions are met:

1. The Paramedic assessment reveals a stable patient that in the Paramedic judgment leaves no index of suspicion that would require ALS treatment.

2. No ALS interventions have been started. Skills and medications within the EMT scope of practice DO NOT constitute ALS interventions.

3. Patient does not meet the unstable definitions as outlined below and as defined in MVEMSA policy 954.20 Stanislaus County BLS Tiered Response System
   - Potentially unstable adult patient:
     - Cardiac Arrest
     - Heart Rate < 50 or > 120
     - Systolic Blood Pressure < 90mmHg
     - Respiratory Rate > 24
     - 02 sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate
   - Any patient that meets trauma activation criteria per MVEMSA Policy 553.25 Trauma/Burn Triage and Patient Destination
   - Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.

- Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
  - Tone
  - Interactiveness
  - Consolability
  - Look/gaze
  - Speech/cry
- Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
  - Stridor
  - Wheezing
  - Grunting
  - Tripod positioning
  - Retractions
  - Nasal flaring
  - Apnea/gasping
- Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
  - Pale
  - Mottled
  - Cyanotic

- Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

V. PROCEDURE

A. A Primary Paramedic that decides to transfer care to another Paramedic, EMT or Flight Nurse shall:

1. Only transfer primary patient care when merited by logistical or operational considerations.

2. Provide complete patient assessment and treatment information to the Paramedic, EMT or Flight Nurse accepting responsibility for the patient.

3. Ensure the completion of a patient care record per Agency policy.

B. The Primary Paramedic shall maintain the lead responsibility and accompany the patient during transport when requested by the EMT or receiving Paramedic due to the patient's condition or complexity of treatment.

C. Disagreements between Paramedics or between Paramedics, EMT's and Flight Nurses regarding the correct course of patient treatment shall be resolved:

1. In consultation with the Base Hospital, if still on scene.

2. Through their respective provider agency's QI program.

3. If unresolved, by submitting an Unusual Occurrence Report Form to the EMS Agency.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 4/15/2016
SUPERCEDES:

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021

CONTROLLED SUBSTANCES

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.220 and 1798(a) and; Title 22, California Code of Regulations, section 100146, section 100167, section 100168 (b)(1).

II. DEFINITIONS

A. "Advanced Life Support Provider" means an agency authorized by the Mountain-Valley EMS Agency to provide ALS services

B. "ALS" means Advanced Life Support as defined in section 1797.52 of Health and Safety Code, Division 2.5.

C. "Back-up ALS Unit" means a fully stocked, equipped and operational ALS unit intended to be put in service on an as-needed basis that is not currently staffed by a Paramedic who is responsible for the Controlled Substances on that unit.

D. "BLS" means Basic Life Support as defined in section 1797.60 of Health and Safety Code, Division 2.5.

E. "Controlled Substances" means Morphine Sulfate, Fentanyl and Midazolam.

F. "In-Service ALS Unit" means any ALS unit that is currently operational and staffed by a Paramedic, who is responsible for the Controlled Substances on that ALS unit.

G. "Out-of Service ALS Unit" means any ALS unit that is neither currently operational nor staffed by a Paramedic who is responsible for the Controlled Substances on that ALS unit.

III. PURPOSE

To provide maximum security for Controlled Substances on ALS units while ensuring that a minimum necessary requirement for Controlled Substances on ALS ambulances are met.

IV. POLICY

A. All Advanced Life Support personnel and Advanced Life Support Service Providers are responsible for the security of Controlled Substances in accordance with this policy.

B. Advanced Life Support Providers shall have a physician in the role of Medical Director. This Medical Director may purchase Controlled Substances with Drug Enforcement Agency Form 222 from a pharmacy or pharmaceutical supply agency and supply these Controlled Substances to the Advanced Life Support Service Provider.

V. PROCEDURE

A. Supply

1. Each authorized in-service ALS unit shall be stocked with the following Controlled Substances in the amounts listed:

a. **Morphine sulfate:**

Minimum amount on hand: 20 mg
Maximum amount on hand: 60 mg

AND/OR

b. **Fentanyl:**

Minimum amount on hand: 200mcg
Maximum amount on hand: 400mcg

c. **Midazolam:**

Minimum amount on hand: 20 mg
Maximum amount on hand: 40 mg

2. ALS Service Providers shall provide written notification to the Agency of the number of units to be stocked with Controlled Substances.

3. All Controlled Substances shall be supplied in single-unit dose (tamper-evident, when possible) containers, protected from light, and maintained within the manufacturer suggested temperature range whenever possible. Providers shall address the stocking of single-unit dose tamper evident containers in their Provider Controlled Substance Policy.

B. Storage and Access

1. All Controlled Substances will be secured under double lock (two separate locking mechanisms) at all times except when being administered to a patient.

2. Access to keys allowing access to Controlled Substances shall be limited to the Paramedic assigned to an in-service ALS unit. These keys should be passed from the

off-going Paramedic to the on-coming Paramedic when the Controlled Substance Log entry is completed for that shift change.

a. At no time shall Controlled Substance storage box keys be in the possession of off-duty personnel.

b. A duplicate set of unmarked keys may be kept by the ALS Service Provider. Duplicate keys must be kept in a locked compartment, on company grounds, with access by no more than three (3) management personnel approved by the Agency. A complete list of personnel with access to the duplicate Controlled Substance keys must be submitted to the Agency. This list must be updated within three (3) days of having someone removed or added to the list.

c. All Controlled Substance keys must be engraved "Do Not Duplicate."

d. If any key which allows access to Controlled Substances or to the duplicate set(s) of keys is lost or stolen, an Unusual Occurrence Report (UOR) shall be filed with the Agency or his/her designee within 24 hours of discovery. The Agency will evaluate the report and decide the appropriate action necessary to resolve the situation.

C. Initial ALS Unit Stocking Procedures

1. Controlled Substances shall be purchased by the ALS Provider physician Medical Director and assigned to its ALS response vehicles according to Drug Enforcement Agency regulations.

2. The person having the prescription filled and the Paramedic responsible for Controlled Substances must sign the Controlled Substance Log at the time the prescription is placed in an ALS unit.

D. Resupply of Controlled Substances

1. When a Controlled Substance is used in the field, resupply shall be provided from the supply provided by the ALS Provider physician Medical Director.

a. Unused drugs must be wasted in the presence of the Emergency Department Registered Nurse and the ALS personnel seeking resupply. The Registered Nurse and the ALS personnel must co-sign to document the wasting of the unused drugs.

E. Exchange of Controlled Substances

1. Controlled Substances, soon to expire Controlled Substances, or damaged Controlled Substance containers must be replaced by the ALS Provider physician Medical Director. The broken or out-dated drug must be presented to receive a replacement.

2. If damage to a Controlled Substance container has caused a loss of the substance or the substance is being exchanged due to findings resulting from an examination; a UOR shall be filed with the Agency within twenty-four (24) hours of findings. The

Agency will investigate the UOR and report their findings to the ALS provider management and Medical Director.

F. Record Keeping/Shift Change

1. Each ALS unit will maintain a standardized written record of Controlled Substance inventory (Controlled Substance Log) and keep it in the locked storage compartment with the Controlled Substances. The Controlled Substance Log shall be available to the Agency and ALS Provider physician Medical Director for routine inspection, and shall be maintained by the ALS Provider for a period of three (3) years in compliance with the State Board of Pharmacy.

2. At each crew change, the off-going Paramedic responsible for Controlled Substances shall count and examine the Controlled Substance(s) and date, time and sign the Controlled Substance Log over to the on-coming Paramedic responsible for Controlled Substances. The on-coming Paramedic will confirm the count and condition and accept responsibility for the Controlled Substances by signing the Controlled Substance Log. Signing the Controlled Substance Log confirms that the count and supply listed is correct and accurate at that time. A copy of the Controlled Substance Logs shall be made available to the Agency immediately upon request.

G. Inventory Discrepancies

1. If at any time the Controlled Substance count is incorrect and the missing substance(s) cannot be accounted for, the Paramedic responsible for Controlled Substances on that unit shall:

   a. Immediately inform his/her supervisor of the incident.

   b. Immediately notify the Agency Duty Officer.

   c. File an Unusual Occurrence Report with the Agency within twenty-four (24) hours of findings.

   d. Be prohibited from going off duty until their supervisor and the Agency Duty Officer are notified.

H. Removing an ALS Unit from Service

1. The security and responsibility for Controlled Substances on out-of-service and back-up ALS units is as follows:

   a. When an ALS unit is taken out-of-service or is being placed on back-up, the Paramedic responsible for Controlled Substances shall count and examine the Controlled Substances, enter the date and time, and sign the Controlled Substance Log. The Paramedic must also note on the Controlled Substance Log that the ALS unit is out-of-service or on back-up. A second ALS Provider staff person must also verify the count and accuracy of the Controlled Substance Log. This second person must either be another Paramedic, or a member of the ALS Service Provider's staff that has been

approved by the Agency. This staff person must either be the sole resupply person or an assigned administrative staff person for the ALS Service Provider.

b. The Controlled Substances and the Controlled Substance Log shall be kept in the permanent key locked storage compartment, located in the ALS unit. The outside doors of the ALS unit shall remain locked, while the unit is unattended.

c. The Controlled Substance keys for that ALS unit shall be kept by the ALS Service Provider staff person as described in H.1.A.

2. Upon request, the Agency may allow ALS service providers to utilize alternate procedures than are specified in Section V, Letter D. Alternate procedures shall be written as company policy and must have the written approval of the Agency. The Agency shall have the authority to enforce alternate procedures as Agency policy.

I. Placing an ALS Unit in Service

1. The responsibility of Controlled Substances on out-of-service and back-up ALS units rests solely with the ALS Service Providers. ALS Service Providers are required to have a company policy and procedure that addresses the following:

a. The storage of Controlled Substances on out-of-service ALS units leaving company grounds.

b. The procedure for turning over Controlled Substance storage compartment and lock box keys to the on-coming crew when the unit has been out-of-service or unstaffed on back-up.

2. If an ALS stocked unit is placed in-service as a BLS unit, the responsibility for the Controlled Substances on that unit remains with the ALS Service Provider. The keys which allow access to the Controlled Substances must remain under the control of the ALS Service management.

3. Current ALS Service Providers must submit their company's Controlled Substance Policy and Procedure to the Agency for review and approval, within sixty (60) days of the effective date of this policy. New ALS service providers must submit the above policy for review and approval prior to the providing of service. Agency staff shall be available to assist ALS providers in establishing company policies that will meet Agency approval.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 11/9/11
SUPERSEDES:
REVISED: 11/2011
REVIEW DATE: 11/2016

EMS AIRCRAFT REQUEST/CANCELLATION

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, Section 1797.220, California Code of Regulations, Title 22., Prehospital Emergency Medical Services, Chapter 8., Prehospital EMS Aircraft Regulations, Title 21, Public Works Chapter 2.5 Division of Aeronautics (Department of Transportation), Public Utilities Code Section 21662.1., and Federal Aviation Regulations

II. DEFINITIONS

Reference the EMS Aircraft Definitions Policy #441.00.

III. PURPOSE

The purpose of this policy is to specify the appropriate procedure to request and/or cancel the dispatch of an EMS aircraft.

IV. POLICY

A. The EMS Agency shall designate a County Air Resource Center (C.A.R.C.) in each county to be the primary coordination point for all EMS Aircraft requests for all field emergencies. Unless otherwise specified, this center shall be the EMS Ground Ambulance Dispatch Center for the county.

B. Each C.A.R.C. shall adopt a plan for requesting EMS aircraft that ensures that they are the primary coordination point for all EMS aircraft field requests in the county.

C. Each C.A.R.C. shall install and utilize EMSystem to track availability of EMS Aircraft.

D. Each C.A.R.C. shall install and utilize a data system to document data requirements of this policy.

E. Requests for EMS aircraft resources may be made:
1. for field emergencies by medical or public safety personnel as identified in Section V (E.1), by contacting the applicable C.A.R.C.; or,
2. for interfacility transfers from personnel at a licensed acute care hospital who shall call directly to the Air Ambulance Dispatch (A.A.D.) of their choice.

F. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft.

1. In the event two air ambulances are co-located or nearly co-located, the C.A.R.C. shall have a policy to rotate calls between those providers which must be approved by the Agency. If closest EMS Aircraft Provider is not available, the C.A.R.C. will request the next closest available provider.

2. If an EMS Aircraft Provider has turned down the flight due to weather considerations, the C.A.R.C. shall notify other EMS Aircraft Providers requested to take the flight that another provider declined to respond based upon weather conditions.

G. The C.A.R.C. shall:

1. maintain a master listing of all Regionally authorized EMS aircraft
2 act as the communication coordination point between responding EMS ground units and the EMS Aircraft responding to the scene of the field emergency
3. maintain records of all EMS Aircraft utilization within its jurisdiction
4. have a method to determine the closest EMS Aircraft Provider to an incident
5. have the capacity and check EMSystem for current updates of the location of all authorized EMS aircraft as they are provided by the air ambulance providers.

H. The C.A.R.C. shall request EMS aircraft dispatch in conjunction with the dispatch of all appropriate first responders and ground ambulances by any of the following methods:

1. Simultaneous Dispatch
2. On Scene Request
3. EMS unit request while en route to an emergency

I. Interfacility transfers utilizing EMS aircraft shall be requested/canceled by physicians or hospital personnel at either of the two acute care facilities initiating and receiving the patient transfer.

V. <u>Procedure</u>

A. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft provider and provide the necessary information as outlined in this policy.

B. The minimum data to be recorded by the C.A.R.C. for each EMS aircraft request shall include:

1. Incident number
2.. date requested
3. time requested
4. agency that requested service
5. agency that canceled service

. 6. estimated time of arrivalof aircraft

C. Required Information for Request of EMS Aircraft

1. The EMS Aircraft shall be requested by the C.A.R.C. as soon as the following essential information is received from the reporting party:
   a. requesting agency
   b. location
   c. number of patients - if known
   d. type of incident
   e. extent of injuries or illness, if known

2. Before completing a call, dispatchers at the C.A.R.C. shall attempt to obtain the following information from individuals/organizations requesting EMS aircraft services and pass the information on to the responding EMS Aircraft.
   a. Landing site information (if possible)
      (1) coordinates
      (2) landmarks identifiable from the air
      (3) designated landing zones
      (4) cross streets
      (5) township
   b. Terrain and obstacles
   c. Weather conditions
      (1) wind direction and speed
      (2) visibility
      (3) temperature
   d. Responding EMS services (air or ground)
      (1) ground frequencies and PLs on which they may be contacted

D. Simultaneous EMS Aircraft Dispatch Criteria

1. C.A.R.C.s or authorized EMS dispatch agencies shall simultaneously dispatch the closest ground ambulance and request that the closest air ambulance respond to those incidents within the simultaneous dispatch zone when the information received from the calling party indicates the incident involves a:

   a. Gun shot wound
   b. Stabbing to head, neck, or torso
   c. Fall greater than 20 feet
   * d. Motorcycle accident
   * e. Auto vs. pedestrian
** * f. Motor vehicle accidents with high speed potential
   g. Explosions
   h. Electrocution
   i. Multi-Casualty Incident
   j. Industrial/Agricultural/Logging Accident with Major Injuries

* Unless low speed and only minor injuries are specified.
** Each county should identify their areas of high speed potential.

E. On Scene Request Criteria

1. An EMS aircraft and ALS ground unit shall be dispatched upon request of any on-scene fire or law enforcement agency, ambulance personnel, other first responders, , clinic, physician's office, or any public safety officer if any of the following conditions are present:

   a. Potential life or limb threatening injuries where transport time to the appropriate medical facility would be significantly reduced by use of the helicopter.
   b. Unavailability of an ALS ground ambulance.
   c. Any other incident where additional ALS assistance is needed.

2. During any scene call in which a medical facility, clinic, or physician's office requests air transport to a destination not consistent with agency policy, the base hospital shall be contacted and approve the destination request.

F. En route Request Criteria

1. Responding emergency personnel that have knowledge of the scene or additional information beyond that provided by the C.A.R.C., may ask that an EMS aircraft be dispatched. After assessing the scene the emergency personnel shall immediately cancel or ask for a continued response by the EMS Aircraft.

G. Cancellation of EMS Aircraft

1. All EMS aircraft cancellations shall be coordinated by the C.A.R.C.
2. Cancellation of EMS aircraft service may occur due to:
   a. Pilot Judgment: The pilot may cancel the mission due to weather conditions or pilot judgment. The Air Ambulance Dispatch shall immediately notify the C.A.R.C. of the reason for cancellation.

      The C.A.R.C. shall request another EMS Aircraft if the reason for cancellation by the original pilot is due to:
      1) lack of pilot's specific knowledge of unsafe conditions at the scene of the emergency
      2) inclement weather en route to the emergency
      3) inclement weather at the EMS Aircraft provider's base of operations

      The C.A.R.C. shall inform the subsequent EMS aircraft provider(s) of the circumstances of the original mission cancellation. The C.A.R.C. shall relay all information concerning the cancellation and/or dispatch of another EMS aircraft to the Incident Commander,

   b. Poor weather conditions at the scene: The C.A.R.C. will not request additional EMS Aircraft if the reason for cancellation is due to inclement weather at the scene of an emergency.

   c. Lack of emergency medical need: The Paramedic, EMT, or recognized first responder working within the EMS system who cancels the assigned EMS aircraft because of lack of medical need shall be on scene and have

knowledge of the patient's medical condition. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and identification of the Air Operations Director, IC, or Medical Group Supervisor.

d. Logistical and/or safety considerations: The Incident Commander (IC) or his designee may cancel the air ambulance when he feels that landing the helicopter would be unsafe, or there is no appropriate landing zone, or there is no patient. Alternate landing zones should be considered. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and IC identification. The C.A.R.C. shall then call the A.A.D. to cancel the air ambulance.

3. C.A.R.C. Dispatchers will cancel an EMS aircraft mission only after documenting:

a. Pilot Judgment: Verify from the pilot the reason for cancellation.
b. Lack of medical need: Verify from the EMS provider the following:

(1) The name of the agency canceling the mission.
(2) Confirm that the agency canceling the mission is on scene.

c. Logistical and/or safety considerations: Verify from the calling party the following information:

(1) The Incident Commander canceling the mission.
(2) The logistical and/or safety consideration why the mission is canceled.
(3) Verification as to whether a medical need still exists.
(4) Alternate landing sites.

WHENEVER THE DISPATCHER CANNOT COMPLETELY VERIFY THAT ALL CRITERIA FOR CANCELLATION ARE MET, THE MISSION WILL NOT BE CANCELED. C.A.R.C. Dispatchers, however, shall notify the A.A.D. of the dispatched EMS Aircraft that an unverified request for cancellation has been received. Cancellation of EMS aircraft will occur only when verified cancellations are obtained.

---END OF POLICY 445.00---

POLICY: 522.20
TITLE: Stroke Triage, Treatment and Destination

EFFECTIVE: 10/22/20
REVIEW: 10/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Stroke Triage, Treatment and Destination

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170, California Code of Regulations, Title 22, Division 9

II DEFINITIONS

A. **ALS** - means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

B. **Cincinnati Prehospital Stroke Scale (CPSS) -** means a validated prehospital screening tool used to identify the presence of a stroke in a patient. The scale tests for facial droop, arm drift and speech. If any one of these three tests show positive findings, the patient is considered to have an abnormal CPSS.

C. **Emergency Medical Services (EMS)** - means the services utilized in responding to a medical emergency.

D. **MVEMSA** - means Mountain-Valley EMS Agency.

E. **MVEMSA Stroke Criteria** - means a patient stroke assessment using the Cincinnati Prehospital Stroke Scale and the VAN (vision, aphasia, neglect) resulting in a positive finding in either assessment tool.

F. **Primary Stroke Center (PSC)** - means a hospital designated to stabilize and treat acute stroke patients, providing initial acute care. PSCs are able to appropriately use t-PA/alteplase and other acute therapies such as stabilizations of vital functions, provision of neuroimaging procedures, and management of intracranial and blood pressures. Based on patient needs and the hospital's capabilities, they either admit patients or transfer them to a comprehensive stroke center.

G. **Quality Improvement (QI)** - means a method of evaluation of services provided, which includes defined standards, evaluation methodologies and utilization of evaluation results for continued system improvement. Such methods may include, but are not limited to, a written plan describing the program objectives, organizations, scope and mechanisms for overseeing the effectiveness of the program.

H. **Stroke** - means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction.

I. **Stroke Alert** - means a notification from the transporting ground or air ambulance to a PSC

or CSC that a patient meeting MVEMSA Stroke criteria is being transported to their facility. A Stroke Alert must be made as soon as possible after stroke criteria is confirmed..

J. **Comprehensive Stroke Center (CSC)** – refers to a hospital that has received comprehensive status through American Heart Association (AHA) and Joint Commission review. CSC sites have availability of advanced imaging techniques including Computed Tomography Angiogram/Perfusion (CTA/CTP), Transcranial Doppler (TCD). These facilities have 24/7 availability of personnel, imaging, operating room and endovascular facilities allowing for the management of large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

K. **VAN (vision, aphasia, neglect) Assessment** - means a prehospital screening tool used to identify the presence of large vessel occlusive stroke. The patient is deemed to have a positive VAN assessment with any arm weakness and at least one of the following; vision change, aphasia or neglect on exam. A VAN negative exam is either no arm muscle weakness OR the presence of arm muscle weakness without vision, aphasia or neglect findings.

L. **Large Vessel Occlusion (LVO)** – refers to the site of an ischemic clot within the brain leading to stroke symptoms. LVO strokes may benefit from transport to a CSC facility per MVEMSA Stroke Destination Policy.

III PURPOSE

To rapidly identify suspected acute stroke patients, provide treatment and prompt transport, to the appropriate Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) for rapid evaluation and treatment.

IV. POLICY

A. STROKE SYSTEM TRIAGE

1. Appropriate triage of the suspected acute stroke patient using stroke alert criteria relies on rapid prehospital care:

    a. Recognition of signs and symptoms of stroke using CPSS and VAN assessment for LVO.

    b. Determination of time last known well without stroke symptoms within the past 24 hours by a reliable historian.

2. Stroke Alert notification to PSC or CSC to report positive stroke assessment findings.

B. TREATMENT PROTOCOL: Characterized by weakness or paralysis on one side of the body or face, slurred speech, speech difficulty, trouble with balance, could struggle in naming objects, confusion, difficulty swallowing, headache, visual disturbances (double vision, blindness, paralysis of extra-ocular muscles). **Decreased level of consciousness is very rarely caused by an Ischemic stroke.**

EMR Standing orders	
Patient Assessment	Circulation, Airway and Breathing. Assess vitals every 5 minutes. Consider trauma mechanism and maintain patent airway
Oxygen Administration	Provide oxygen therapy if appropriate
TLKW	Attempt to obtain a specific time patient was last known well and report to transporting paramedic

EMT Standing orders	
Note	Must perform items in EMR standing orders if applicable.
TLKW	Attempt to obtain specific time patient was last known well and report to the transporting paramedic
Glucometer	Check blood sugar
Glucose	Oral glucose if patient can protect airway, has a gag reflex, and if blood sugar is <60mg/dl.
Pulse Oximetry	Consider if respiratory distress is observed or suspected, use pulse oximetry, and record initial reading before supplemental oxygen is given. Report initial reading to the transporting paramedic.
Naloxone	2mg IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2mg, may repeat dose once in 3 minutes if there was no response to initial dose. Max total dose of 4 mg.

Paramedic Standing Orders	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate and obtain 12 lead EKG
Temperature	Consider sepsis for any altered patient with a fever
IV/IO Access	TKO. If systolic BP is < 90mmHg, give 250ml fluid boluses to systolic BP 90-100 or a max of 2 liters. Shall reassess vitals/patient after each bolus. If time permits, 2 IV sites are preferred.
Dextrose	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
Glucagon	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose.
Naloxone	2 mg IV/IO/IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2 mg, may repeat once in 3 minutes if there was no response to initial dose. Max total dose of 4mg.
Stroke scale	Perform, document and report to receiving hospital the Cincinnati Prehospital Stroke scale. If Cincinnati Prehospital Stroke Scale is positive, paramedic shall perform, document and report a VAN positive or negative to the receiving hospital

C. DESTINATION

1. Suspected acute stroke patients shall be transported to the appropriate PSC or CSC within the following parameters:

   a. If the patient has a positive Cincinnati Prehospital Stroke Scale assessment and is found to be **VAN positive** the patient may be transported directly to a CSC if the following criteria are met:

      i. Last known well time is within 24 hrs.

      ii. Transport time to the CSC will not exceed 60 minutes.

      iii. Transport time will not take the patient out of the 4.5-hour window for thrombolytic therapy from onset of symptoms or TLKW.

   b. If the patient has a positive Cincinnati Prehospital Stroke Scale assessment, and is found to be **VAN negative**, the following transport criteria shall be followed:

      i. If the patient does not have a preference, the patient shall be transported to the nearest PSC or CSC

      ii. If transport to a PSC or CSC is estimated to be greater than twenty (20) minutes, the patient shall be transported to the nearest ED facility capable of receiving stroke patients.

      iii. All emergency rooms can receive stroke patients.

   c. Paramedics in Mariposa, Amador and Calaveras Counties may exercise their judgment and, in communication with the base hospital, request air transport (if available) for stroke patients to a PSC or CSC.

   d. Unstable stroke patients shall be transported to the closest emergency department. Unstable stroke patients are defined as any ONE of the following:

      i. Patients under CPR.

      ii. Inability to ventilate and/or oxygenate the patient with BLS maneuvers.

2. A PSC/CSC may request advisory status through the EMS Duty Officer for incoming stroke patients only when:

   a. The PSC/CSC is on internal disaster; or

   b. Inoperable CT/MRI.

3. Patients may be taken directly to the CT scanner.

   a. The patient is to remain on cardiac monitor if taken directly to the CT. The patient will remain on the cardiac monitor until Paramedic transfers patient care.

   b. Paramedic will give report to the nurse, transfer patient directly from gurney to CT scanner platform and return to service.

   c. If there is any delay, such as CT scanner not being readily available, the paramedic will not be expected to wait. The patient will be taken to a monitored bed and report given to a receiving nurse or physician as is customary.

D. STROKE ALERT/PATIENT REPORT

1. As soon as a suspected stroke patient is confirmed with CPSS and VAN assessments, the appropriate destination shall be determined, and a Stroke Alert promptly communicated to the PSC/CSC and/or the closest receiving facility. The Stroke Alert is to contain the following information:

   a. Identify the call as a "Stroke Alert" and verify CT operability.

   b. Provide estimated time of arrival (ETA).

   c. Patient's age and gender.

   d. Give time patient was last seen without stroke symptoms (Last Known Well Time).

   e. CPSS and VAN assessment result-negative or positive.

   f. Blood Glucose and Vital Signs.

   g. Treatment and response to treatment.

2. Electronic Patient Care Report(ePCR) documentation must include:

   a. Time last known well CPSS and VAN assessment results, transport factors that determined patient destination

   b. Blood glucose check

   c. Neurological assessments

CINCINNATI PREHOSPITAL STROKE SCALE			
Sign/Symptom	How Tested	Normal	Abnormal
Facial Droop	Have the patient show their teeth, or smile.	Both sides of the face move equally.	One side of the face does not move as well as the other.
Arm Drift	The patient closes their eyes and extends both arms straight out for 10 seconds	Both arms move about the same, or both do not move at all.	One arm either does not move, or one arm drifts downward compared to the other.
Speech	The patient repeats "The sky is blue in Cincinnati."	The patient says the correct words with no slurring of words	The patient slurs words, says the wrong words, or is unable to speak.

V.A.N STROKE SCALE		
	Sign/Symptom	How Tested
Vision	Forced gaze to one side, Loss of vision, or uneven eyes.	Have patient follow your finger with their eyes moving to left, then right.
Aphasia	Difficulty naming objects or repeating simple phrase. (Usually seen with right sided CPSS positive patients)	Ask patient to name two easily identified objects (ie, pen and watch). Have patient repeat "The sky is blue in Cincinnati". DO NOT CONSIDER DYSARTHRIA (Slurring of words)
Neglect	Patient ignores left side of body. (Usually seen with left sided CPSS positive patients)	Have patient close their eyes, and touch individually the right arm, then left arm and confirm patient has sensation bilaterally. Then touch both arms simultaneously and note if patient no longer has sensation unilaterally.

Clinical PEARLS

- Time of onset must be within a 24-hour timeframe and confirmed by a reliable historian
- Do not hesitate to activate a Stroke Alert to the receiving hospital if the condition warrants
- High index of suspicion of hemorrhagic stroke in a non-traumatic altered patient
- History of previous stroke or neurological deficits
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 250ml drip if D50W is unavailable and Blood Glucose <60. Continue D-10W until patient symptoms improves
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Naloxone- May use the prescribed grant administered aerosol 4mg doses if that is all that is available
- Naloxone must be administered prior to intubation if narcotic overdose is suspected
- MICN- If Time Last Known Well is not reported via radio report, ask!
- MICN-confirm CT status when stroke alert is received

STEMI TRIAGE AND DESTINATION

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170

II. DEFINITIONS

A. "STEMI" means an acute myocardial infarction that generates a specific type of ST-segment elevation on a 12-lead ECG.

B. "STEMI Alert" is a report from prehospital personnel that notifies a STEMI Receiving Center or STEMI Referral Hospital as early as possible that a patient has a specific computer-interpreted Prehospital 12-lead ECG indicating a STEMI.

C. "STEMI Receiving Center (SRC)" is a hospital in the Mountain-Valley EMS Agency region that has an interventional cardiology lab licensed by the Department of Health Services which provides emergent cardiac catheterization 24 hours a day, 7 days a week, 365 days a year, with an established quality assurance program and a written commitment by the hospital administration supporting the center's interventional cardiology mission for STEMI patients.

D. "STEMI Referral Hospital (SRH)" is any hospital in the Mountain-Valley EMS Agency region that lacks the availability or continuous availability of 24/7/365 cardiac catheterization. These hospitals will have the ability to administer thrombolytics to a STEMI patient. These hospitals will also have written transfer policies for STEMI patients to STEMI Receiving Centers.

E. "STEMI Patient" means a patient 18 years of age or greater who has received a 12 lead electrocardiogram in the pre-hospital environment that stipulates ***Acute MI Suspected*** or "ECG Suggestive of Acute MI" on the computer interpretation on the ECG.

F. "Pre-Hospital Care Provider" means the ambulance service provider, fire service agency, or any other emergency service provider authorized by Mountain-Valley EMS Agency.

G. "ALS" means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

III. PURPOSE

To establish guidelines for prehospital personnel to identify and transport patients with acute ST-Elevation Myocardial Infarction (STEMI) who may benefit from the rapid response and specialized services of a STEMI Receiving Center (SRC).

IV. POLICY

This policy applies to adult patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) with a 12-lead ECG demonstrating elevated ST-segments indicating a specific type of myocardial infarction.

V. TRIAGE

A. Patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) shall have a 12-lead ECG performed.

1. 12-lead ECG's showing suspected STEMI will be transmitted to SRC by Pre-hospital Care Provider's 12-lead ECG transmission device.

2. Exceptions include patients who are not cooperative with the procedure or patients in whom the need for critical resuscitative measures preclude performance of 12-lead ECG.

3. Paramedic shall review the 12-lead ECG tracing in all instances to assure that little or no artifact exists (steady baseline, lack of other electrical interference, complete complexes present in all 12 leads). Repeat ECG may be necessary to obtain an accurate tracing.

B. If computerized interpretation of accurately performed 12-lead ECG indicates either ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***, the patient qualifies as a candidate for transport to a STEMI Receiving Center. Patients without these findings shall be transported per MVEMSA Policy 511.00.

Note: Hypotensive STEMI patients should be transported to the closest ED.

VI. DESTINATION

A. With consent, a patient with an identified STEMI should be transported to a designated STEMI Receiving Center if estimated transport time is 60 minutes or less. If the patient has a preference or has a cardiologist associated with a designated STEMI Receiving Center, the patient shall be transported to their preferred hospital. If the patient does not have a preference, the patient shall be transported to the NEAREST STEMI Receiving Center.

B. If transport time to a STEMI Receiving Center is estimated to be greater than sixty (60) minutes, the patient shall be transported to a designated STEMI receiving center in an

adjoining county if transport time is less than 60 minutes to that center. In cases where there is no SRC within 60 minutes the patient shall be transported to the nearest STEMI Referral Hospital. Paramedics in Mariposa, Amador and Calaveras counties may exercise their judgment and, in communication with the base hospital, request air transport (if available) of STEMI patients to a SRC.

C. Unstable STEMI patients shall be diverted to the nearest emergency department. Unstable STEMI patients are defined as any ONE of the following:

1. Patients under CPR

2. Inability to ventilate and/or oxygenate the patient with BLS maneuvers.

D. A STEMI Receiving Center may request advisory status for incoming STEMI patients only when:

1. The STEMI Receiving Center is on internal disaster; or

2. The Cardiac Catheterization laboratory is closed for repair or upgrade.

VII. STEMI ALERT/PATIENT REPORT

A. The STEMI Alert should contain the following information:

1. Situation:

a. Identification of the call as a "STEMI Alert."

b. Estimated time of arrival in _____ minutes for STEMI.

c. Patient age and gender

d. Confirm ECG states ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***

e. If patient elects to go to a facility that is not a STEMI designation receiving center

f. Any urgent patient concerns

2. Background:

a. Patient presenting complaint including any duration and presence/absence of chest pain, pressure, jaw pain, or SOB.

b. Pertinent past cardiac history including presence of a pacemaker

3. Assessment:

a. General Impression

b. Patient improved or worse since on scene

c. Pertinent vital signs and significant abnormal physical examination findings

4. Treatment:

a. Prehospital treatment given and response to treatment

VIII. DOCUMENTATION

A. A copy of the 12-lead ECG shall be delivered to the nurse or doctor caring for the patient at arrival in the Emergency Department

B. A copy of the 12-lead ECG shall be generated for inclusion in the Prehospital Patient Care Report (PCR) or incorporated via electronic means into the record. The finding of STEMI on 12-lead ECG and confirmation of the STEMI Alert shall also be documented on the PCR.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 2/1998
SUPERSEDES:
REVISED: 8/2007
REVIEW DATE: 8/2012

INTRAVENOUS INFUSIONS OF HEPARIN & NITROGLYCERIN

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

II. PURPOSE: To provide a mechanism for EMT-Ps to monitor intravenous infusions of heparin and nitroglycerine during interfacility transfers

I. POLICY:

A. Only those EMT-Ps who have successfully completed training program(s) approved by the Mountain-Valley EMS Agency Medical Director on nitroglycerin and heparin infusions will be permitted to monitor them during interfacility transports.

B. Only those ALS ambulance providers approved by the Mountain-Valley EMS Agency Medical Director will be permitted to provide the service of monitoring nitroglycerin and/or heparin infusions during interfacility transports, from approved hospital(s) within their service area.

IV. PROCEDURE:

A. PRIOR TO TRANSFER:

1. Patients that are candidates for paramedic transport will have pre-existing heparin and/or nitroglycerin drips in peripheral lines only.

2. Heparin and nitroglycerin drips will not be initiated immediately prior to transport.

3. Patients will have maintained stable vital signs for a period of time as determined by the transferring physician.

4. Patients will not have more than two medicated drips running, exclusive of potassium chloride (KCl).

5. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the EMT-P.

6. Transferring physicians must be aware of the general scope of practice of paramedics and the transport protocol parameters outlined below.

7. EMT-Ps are allowed to transport patients on heparin and nitroglycerin drips within the following parameters:

a. Nitrogycerin

(1) Infusion fluid will be D5W or NS. Medication concentration will be either 25 mg/ 250 cc or 50 mg/250 cc.

(2) Physician orders regarding regulation of the drip rate will be within parameters as defined by the transferring physician, but in no case will changes be in greater than 5 mcg/minute increments every 10 minutes. In cases of severe hypotension, the orders should state that the nitroglycerine drip will be discontinued and the transferring hospital and base hospital is to be notified.

(3) Absolute drip rates will not exceed 100 mcg/minute.

b. Heparin

(1) Infusion fluid will be D5W or NS. Medication concentration will be 100 U/cc of IV fluid (25,000 U/ 250cc).

(2) Drip rates will remain constant during transport. No regulation of the rate will be performed, except to turn off the infusion completely.

(3) Drip rates will not exceed 1600 U/hour.

8 Patients will meet pre-established hospital criteria for hemodynamic stability.

9. The transferring physician or nurse on shall complete a "Heparin-Nitroglycerin Paramedic Transfer Checksheet," which identifies the hemodynamic criterion utilized, and that all criteria for transfers as outlined in this section have been met.

10. Signed orders from the transferring physician will be obtained prior to transport and reviewed with the transporting paramedic(s).

B. DURING TRANSPORT

1. Heparin and nitroglycerin drips will <u>not</u> be initiated by prehospital personnel

2. All patients will be maintained on a cardiac monitor and a non-invasive blood pressure monitor that will record blood pressure readings every five (5) minutes.

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

4. In cases of IV pump malfunction that cannot be corrected, the medication drip will be discontinued and the transferring hospital and base hospital will be notified.

5. In cases of severe hypotension, nitroglycerin drips will be discontinued and the transferring hospital and base hospital is to be notified

6 Vital signs will be monitored and documented every 5 minutes.

7 No other medication shall be given thru the same line.

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

POLICY: 553.25
TITLE: Trauma/Burn Triage & Patient Destination

EFFECTIVE: 4/13/17
REVIEW: 4/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Trauma/Burn Triage & Patient Destination

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.222, 1798.162, 1798.163
California Code of Regulations Section 100255.

II. DEFINITIONS

A. **"Pediatric" or "pediatric patient"** means an individual age 14 and under.

B. **"Pediatric Trauma Center"** means a designated facility identified by the Mountain-Valley EMS Agency (MVEMSA) to receive pediatric trauma patients directly from the field, including:

1. UC Davis Medical Center (Level I)
2. Children's Hospital, Oakland (Level I)
3. Renown Regional Medical Center, Reno Nevada (Level II)
4. Valley Children's Hospital, Madera (Level II)

C. **"Trauma Center"** means a designated facility identified by the Mountain-Valley EMS Agency (MVEMSA) to receive trauma patients directly from the field, including:

1. Doctors Medical Center (Level II)
2. Memorial Medical Center, Modesto (Level II)
3. "Trauma Centers" may be designated by other Local EMS Agencies and in some cases, may be the closer facility. If this is the case, trauma patients may be transported directly from the field, these include:

   i. UC Davis Medical Center (Level I)
   ii. Mercy San Juan (Level II)
   iii. Sutter Roseville (Level II)
   iv. Kaiser South Sacramento (Level II)
   v. Renown Regional Medical Center (Level II)
   vi. San Joaquin General (Level III)

D. **"Trauma"** means physical injury or wound caused by significant external force, high-energy exchange, a rapid deceleration, or violence.

E. **"Trauma Triage criteria"** means a guideline for assessing the severity of a person's potential injuries that is used to direct transportation of trauma patients to the appropriate Trauma Center.

III. PURPOSE

A. To establish guidelines for identifying trauma patients and for determining their destination.

B. To ensure appropriate utilization of resources within the Mountain-Valley EMS system.

IV. POLICY

This policy shall serve to identify patients who are at risk for severe injury and determines the most appropriate destination for transport.

V. PROCEDURE

A. Prehospital EMS Personnel SHALL notify the DCF **IMMEDIATELY** when it is determined that the patient meets trauma triage criteria to establish destination. This notification does not have to originate from the person actually caring for the patient, but may come from another member of the patient care team.

1. DCF notification SHALL include:
    a. age
    b. mechanism
    c. trauma triage criteria
    d. ETA

2. The DCF will immediately assign Trauma Center destination and will inform both pre-hospital EMS personnel and the receiving Trauma Center.

3. A full Base Hospital report to the destination Trauma Center from the pre-hospital provider must follow the DCF notification as soon as possible.

B. Triage Upgrade

A patient's triage status may always be upgraded if the patient's condition deteriorates during assessment or transport. A patient's triage status shall not be downgraded by a Nurse or Paramedic.

C. Destination Decisions

1. All injured patients (Adult & Pediatric) meeting trauma triage criteria shall be transported by the quickest, most appropriate means, ground or air.

    a. If a trauma patient meeting criteria is to be transported by air and environmental conditions do not allow for an air transport, a ground ambulance shall transport to the closest Level I or Level II Trauma Center unless the patient has a life-threatening condition

that overrides the need for expedient surgery. In these cases, trauma patients should be transported to the closest facility. This includes, but is not limited to, conditions such as:

i. Obstructed airways

ii. Tension pneumothorax which has not been relieved or stabilized in the prehospital setting, or

iii. Situations where the patient meets criteria as outlined in policy 570.20 "Determination of Death". Such patients should be transported to the closest appropriate receiving facility or pronounced dead in the field if they meet the criteria outlined in policy 570.20.

b. Pediatric patients meeting criteria to be transported to a Pediatric Trauma Center shall be transported by air ambulance if the environmental conditions allow. If air resources are unavailable and/or patient is not stable for transport to a Pediatric Trauma Center, transport to the closest adult Level I or II Trauma Center is acceptable.

2. If a Trauma Center is on Trauma Bypass, trauma patients will be transported to the next closest available Level I or Level II Trauma Center as directed by the DCF.

3. Patient Destination for Stanislaus County Trauma Centers:

The distribution of patients destined for a Stanislaus County Trauma Center shall be guided by the following:

a. **All** trauma patients requiring transport by air or ground ambulance to a Level II Trauma Center in Stanislaus County will follow an alternating rotation of Trauma Centers. The Stanislaus County DCF will be contacted and will identify the Trauma Center destination. The DCF will contact the Trauma Center with the initial trauma notification. If a trauma patient requires a code three transport by ground ambulance the patient will be taken to the closest Level II Trauma Center in Stanislaus County (DCF contact must still occur).

b. In the event a Level II Trauma Center located within the MVEMSA region meets Trauma Bypass criteria as indicated in Policy 546.10, the facility will immediately notify the Stanislaus County DCF and update its facility status on EMResource to Advisory. When the Trauma Center goes off Trauma Bypass, the facility will immediately notify the DCF and update its status on EMResource.

c. Where response and transportation times permit, two patients requiring trauma activation should not be delivered to the same Trauma Center in the same ambulance (ground or air).

4. Any disputes regarding distribution of patients should be documented on

an Unusual Occurrence Report and faxed to MVEMSA within 72 hours for review.

D. Burn Triage Criteria:

1. A patient (adult or pediatric) whose primary injuries are burns may be transported directly to a Burn Center from the field. These injuries include:

   a. Partial/full thickness (2nd or 3rd degree) burns involving greater than 15% TBSA without airway compromise

   b. Patients with partial/full thickness (2nd or 3rd degree) burns greater than 10% TBSA without airway compromise with the following:

      i. Greater than 60 years of age

      ii. Associated trauma meeting Trauma Triage Criteria (and if transport can be completed within 60 minutes)

      iii. Significant co-morbidities (e.g. COPD, major medical disorder, bleeding disorder or anticoagulant therapy, dialysis patients)

   c. Partial/full thickness (2nd or 3rd degree) burns of face, perineum or circumferential burn to any body part

   d. Significant electrical injuries with loss of consciousness, voltage in excess of 220, and/or open wounds

   e. Electrical injuries resulting in a loss of distal pulses

   f. Significant inhalation injury with successful intubation

   g. Chemical burns with wounds >5% TBSA

2. All burns with airway compromise, wheezing, stridor, carbonaceous sputum, nasal singeing or significant facial edema must have an evaluation for intubation either by air ambulance personnel or by the emergency physician at the closest appropriate receiving facility prior to transport to the Burn Center, if the ground ambulance is unable to intubate the patient.

TRAUMA TRIAGE CRITERIA

Measure Vital Signs and Level of Consciousness

1

• Glasgow Coma Scale	<= 13
• Systolic Blood Pressure (mmHg)	<90 mmHg
• Respiratory Rate	<10 or >29 breaths per minute or need for ventilatory support. (<20 in infant aged <1 year)

YES → **Transport to a Level I or II Trauma Center.** Steps 1 and 2 attempt to identify the most seriously injured patients.

No

Assess Anatomy of Injury

2

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

YES → **Transport to a Level I or II Trauma Center.** Steps 1 and 2 attempt to identify the most seriously injured patients.

No

Assess Mechanism of Injury and Evidence of High-Energy Impact

3

- **Falls**
  - -Adults: >20 feet (one story is equal to 10 feet)
  - -Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - -Intrusion, including roof: >12 inches occupant site; >18 inches any site
  - -Ejection (partial or complete) from automobile
  - -Death in same passenger compartment
  - -Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20 mph**

Yes → **Transport to a trauma center**, which, depending upon the defined trauma system, need not be the highest level trauma center.

No

Assess Special Patient of System Considerations

4

- **Older Adults**
  - -Risk of injury/death increases after age 55 years
  - -SBP <110 may represent shock after age 65
  - -Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - -Should be triaged preferentially to a Pediatric Trauma Center
- **Anticoagulants and bleeding disorders**
  - -Patients with head injury are at high risk for rapid deterioration
- **Bums**
  - -Without other trauma mechanism: triage to burn facility
  - -With trauma mechanism: triage to trauma center
- **Pregnancy >20 weeks**
- **EMS provider judgment**

Yes → **Transport to a trauma center** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries.

No

Transport According to Protocol

When In Doubt, Transport To a Trauma Center

REPORTING OF SUSPECTED ABUSE

I. AUTHORITY

Health and Safety Code, Division 2.5, Section 1798 and; Child Abuse; California Penal Code, Article 2.5; Elder Abuse: Chapter 1273, Statutes of 1983, SB 1210, Sections 9381(a) and 9382. Welfare and Institutions Code Chapter 11, Part 3, Division 9 and California Welfare and Institutions Code Section 15630.

II. DEFINITIONS

A. "Elder" means any person residing in the state of California who is 65 years of age or older (WIC Section 15610.27)

B. "Dependent Adult" means any person residing in the state of California, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23) Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3)

C. "Reasonable Suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect." (CA Penal Code, 11166)

D. "Mandated Reporters" for **Suspected Child Abuse Cases** are defined under CA Penal Code Section 11165.7. Paragraph 20 of subdivision (a) states, "A firefighter, except for volunteer firefighters" and Paragraph 22 of subdivision (a) states, "Any emergency medical technician I or II, paramedic."

California Welfare and Institutions Code Section 15630 (a) defines "mandated reporter" for **Elder Abuse** as follows; "Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

E. "EMS Personnel" means all EMTs and Paramedics providing care within the Emergency Medical Services System.

F. "Designated Agency" means the agency designated by law to receive a copy of the "Suspected Child Abuse Report." The designated agencies are police or sheriff's department, county welfare or probation department, and district attorney's office.

III. PURPOSE

To describe reporting requirements for EMS personnel when child or elder abuse, sexual assault, or domestic violence is observed or is reasonably suspected.

IV. POLICY

EMS personnel are considered mandatory reporters responsible for reporting incidents of sexual abuse, domestic violence, or suspected abuse to children, dependent adults, or elderly people.

V. PROCEDURE

A. Abuse Reporting (Child, Dependent Adult, and Elder)

1. Suspected Child Abuse Report

   a. Immediately notify the appropriate law enforcement agency. The law enforcement officer assigned will act as a "clearinghouse" for taking the next steps and serves as the initial Child Protective Services contact.

   b. If no law enforcement officer is available, the reporter must follow the following steps AFTER THE APPROPRIATE LAW ENFORCEMENT AGENCY HAS BEEN CONTACTED:

   c. Make phone report to Child Protective Services Agency
      1) Stanislaus County – (209) 558-3665
      2) Calaveras County – (209) 754-6452, after hours (209) 754-6500
      3) Amador County – (209) 223-6550, after hours (209) 223-1075
      4) Alpine County – (530) 694-2235 then 1, after hours (866) 900-0525
      5) Mariposa County – (209) 966-7000

   d. Written Report must be followed within twenty-four (36) hours. The written report and instructions on "Suspected Child Abuse Report" is attached. **See attachment 1**.

2. Suspected Dependent Adult/Elder Abuse Report

   a. If the alleged abuse has occurred in a **long-term care facility**:
      1) Call Ombudsman Services of Northern California:
         i. 1-800-896-4042
            TTY 1-800-896-2512

   b. If the alleged abuse has occurred anywhere else:

      1) Call Adult Protective Services
         i. Stanislaus County – (800) 336-4316
         ii. Calaveras County - (209) 754-6452, after hours (209) 754-6500
         iii. Amador County - (209) 223-6550, after hours (209) 223-1075
         iv. Alpine County - (530) 694-2235 then 1, after hours (866) 900-0525
         v. Mariposa County - (209) 966-7000

      2) Written report must be followed within twenty-four (48) hours. The written report and instructions on "Report of Suspected Elder Abuse" is attached. **See attachment 2.**

3. The identity of all persons reported under this article shall be confidential.

B. Sexual Assault

1. Sexual assault shall be reported in situations involving elder, dependent adult, child, or domestic violence.

2. Transport patients who have been sexually assaulted to nearest hospital or hospital of choice for evaluation and evidentiary exam.

3. Discourage any activity that would compromise evidence collection prior to transport such as bathing, brushing teeth, brushing hair, urinating, defecating or changing clothes.

4. Document essential elements:

    a. Name of person making report
    b. Name of victim
    c. Present location of victim
    d. Nature and extent of injury
    e. Information that led reporting person to suspect sexual assault
    f. Other information as requested.

C. Domestic Violence

1. Suspicion is to be reported immediately to the appropriate law enforcement agency.

2. The identity of all persons reported shall be confidential

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Attachment 1

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

OSP 03 74570

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME:_____

PLEASE PRINT OR TYPE

CASE NUMBER:_____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services) AGENCY

ADDRESS Street City Zip DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED – TITLE TELEPHONE ( )

C. VICTIM One Report Per Victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL		CLASS	GRADE
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME	
IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT	PHOTO'S TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK	

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )	

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02) ***DEFINITIONS AND INSTRUCTIONS ON REVERSE***

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY-District Attorney's Office; YELLOW COPY-Reporting Party

Attachment 2

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER ☐ M ☐ F	ETHNICITY	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
		( )	☐ M ☐ F							

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE	(STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)	TELEPHONE
					( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)
☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL
☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
☐ ASSAULT/BATTERY
☐ CONSTRAINT OR DEPRIVATION
☐ SEXUAL ASSAULT
☐ CHEMICAL RESTRAINT
☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION

f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated; e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME IF CONTACT PERSON ONLY ✓ CHECK ☐	*RELATIONSHIP

*ADDRESS	*CITY	*ZIP CODE	*TELEPHONE
			( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE	DATE/TIME
	( )	

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

SOC 341 (12/06)

POLICY: 570.20
TITLE: Determination of Death in the Prehospital Setting

EFFECTIVE: 7/1/2021
REVIEW: 7/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

DETERMINATION OF DEATH IN THE PREHOSPITAL SETTING

I. AUTHORITY

California Health and Safety Code, Division 2.5, sections 1797.220, 1798, and 102850; and California Code of Regulations, Title 22, Division 9, sections 100107.

II DEFINITIONS

A. "Obviously Dead" means a person who, in addition to absence of respiration, cardiac activity (pulseless or asystole/agonal EKG rhythm confirmed in at least two leads), and neurologic reflexes (gag or corneal reflexes) has one or more of the following:

1. Decapitation
2. Massive crushing and/or penetrating injury with evisceration of the heart, lung or brain
3. Incineration
4. Decomposition of body tissue
5. Rigor mortis
6. Post-mortem lividity
7. Evidence of major blunt trauma
8. Pulseless, apneic trauma victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication
9. Pulseless, apneic victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures

B. “Traumatic Cardiac Arrest” means a patient who is pulseless and apneic secondary to a traumatic event and does not meet obviously dead criteria.

III PURPOSE

To establish standards for authorized EMS personnel to follow in determining death of a patient in the prehospital setting.

IV. POLICY

EMS personnel shall not initiate nor perform CPR, basic life support, or advanced life support on patients determined to be obviously dead as defined in this policy.

V. PROCEDURE

A. When the initial patient assessment reveals "obvious death" and/or meets “Traumatic Cardiac Arrest” criteria:

1. A Patient Care Report (PCR) shall be completed. All appropriate patient information must be included in the PCR and shall describe the patient assessment as well as the time the patient was determined to be obviously dead if applicable.

2. <u>Traumatic Cardiac Arrest patients:</u>

a. Briefly assess the patient and determine if the patient meets "Obviously Dead" criteria. If patient meets "Obviously Dead" criteria, do not initiate CPR. Base Hospital contact is not required for patients determined to be obviously dead.

b. Initiate CPR and assess the patient's mechanism of injury (Blunt vs. Penetrating) and cardiac electrical activity.

c. Asystole: Continue CPR for one (1) minute. If still asystole after one (1) minute, CPR can be terminated. EKG rhythm must be verified in two (2) leads and patient's physical findings must be verified by two (2) providers.

d. Pulseless Electrical Activity (PEA) less than 20 beats/minute: Continue CPR for one (1) minute. If still PEA less than 20 beats/minute CPR can be terminated. EKG rhythm must be verified in two (2) leads and patient's physical findings must be verified by two (2) providers.

e. Blunt Trauma: If Estimated Time of Arrival (ETA) to a receiving hospital is greater than five (5) minutes, terminate CPR. If ETA to a receiving hospital is less than five (5) minutes, initiate transport.

f. Penetrating Trauma: If Estimated Time of Arrival (ETA) to a receiving hospital is greater than ten (10) minutes terminate CPR. If ETA to a receiving hospital is less than ten (10) minutes, initiate transport.

g. Pulseless Electrical Activity greater than 20 beats/minute and other heart rhythms (VF/VT): Transport to appropriate facility. Reevaluate. If PEA is less than 20 beats/minute, refer to Section d.

Special Considerations:

1) If EMS personnel are in doubt, CPR should be initiated.

2) EMS personnel must complete two primary assessments, which show no signs of life one (1) minute apart before terminating CPR. Assessments must be confirmed by two providers.

3) Once CPR has been terminated on scene; EMS personnel should consult law enforcement about the disposition of the patient.

4) If CPR is terminated after transport is initiated, continue transport to the closest appropriate hospital.

5) Hanging Considerations: Although hanging is part of trauma in most paramedic texts, the majority of EMS calls dealing with "hanging" are predominantly asphyxiation/strangulation cases. This means patients with a mechanism of injury of a hanging need spinal immobilization and trauma consideration; and should be treated as a medical cardiac arrest if found pulseless and nonbreathing.

6) All Pediatric Traumatic Arrest patients that DO NOT meet "Obviously Dead" criteria shall be transported to the closest acute care facility.

B. For patients who do not meet the "Obviously Dead" definition, appropriate treatment measures shall be initiated.

1. A Base Hospital Physician may determine that intervention is futile or not indicated, and may authorize the discontinuation of resuscitative efforts if all of the following criteria are met:

a. No spontaneous respirations are present after:

1) Assuring the patient has an open airway.

2) Looking, listening, and feeling for respirations, including auscultation of the chest for lung sounds for a minimum of 30 seconds.

b. No pulses are present after:

1) Palpating the carotid pulse for a minimum of 60 seconds.

2) Auscultating the apical pulse for a minimum of 60 seconds.

c. There is no suspected history of hypothermia.

d. If ALS resuscitative measures have been employed, refer to policy 554.11 (Cardiac Arrest Algorithms) for termination of resuscitative efforts.

e. In the event a pulseless patient under BLS only care to whom an AED has been applied for 15 minutes with ongoing CPR, personnel may request Base Hospital Physician authorization to discontinue resuscitation.

f. In the event that BLS has been performed for 30 minutes without improvement in the patient's condition, BLS personnel may request Base Hospital Physician authorization to discontinue resuscitative efforts.

g. In the event that Base Hospital contact cannot be made, EMS personnel may discontinue resuscitative efforts and fully document their actions, as described in e. and f. above.

2. Following an order by the Base Hospital Physician to discontinue resuscitation, a Patient Care Report shall be completed. All appropriate patient information must be included in the PCR, and must fully describe all interventions, the criteria outlining discontinuation of resuscitative efforts, and the time the Base Physician determined the patient to be dead.

C. EMS personnel shall notify the appropriate law enforcement agency when a patient has been determined to be dead and shall remain on scene until released by the law enforcement agency. A body and the patient documentation may be left in the care of an authorized first responder agency, if another patient requires transport or the ambulance has been requested by an authorized ambulance dispatch center to respond to another emergency.

D. In accordance with Agency documentation policy (560.11), the original PCR or Triage Tag shall remain with the body for inclusion in the law enforcement agency's report.

E. If a determination of death is made while transporting a patient from a scene call, transport of the body should continue to the original receiving facility destination.

F. Policies and procedures relating to medical operations during declared disaster situations or multiple casualty incidents will supersede this policy. (See Policies 810.00, 812.00, and 820.00 for disaster policies)

G. Crime Scene Responsibility, including presumed accidental deaths and suspected suicides:

1. Authority for crime scene management shall be vested in law enforcement. To access the patient(s), it may be necessary to ask law enforcement officers for assistance to create a "safe path" that minimizes scene contamination.

2. If law enforcement is not on scene, EMS personnel shall make every effort to preserve the integrity of the scene by minimizing access of unnecessary personnel to the scene until law enforcement arrives.

POLICY: 570.21
TITLE: Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

EFFECTIVE: 07/01/2017
REVIEW: 07/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

I. AUTHORITY

California Health and Safety Code, Division 1, Part 1.8, Section 442-443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

II. DEFINITIONS

A. **Advance Health Care Directive (AHCD)**: A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney.

B. **Aid-in-Dying Drug**: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

C. **Basic Life Support (BLS) Measures:** The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted Ventilation via a bag-valve-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED)

D. **Comfort Measures:** Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

E. **Do Not Resuscitate (DNR):** DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- No chest compressions
- No defibrillation
- No endotracheal intubation
- No assisted ventilation

F. **End of Life Option Act:** California State law authorizes an adult, eighteen (18) years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

G. **Ombudsman:** The Office of the Ombudsman works independently as an intermediary to provide individuals with a confidential avenue to address complaints and resolve issues at the lowest possible level. The Office proposes policy and procedural changes when systemic issues are identified.

H. **Patient Advocate:** Patient advocacy is an area of lay specialization in health care concerned with advocacy for patients, survivors, and care takers. The patient advocate may be an individual or an organization, often, though not always, concerned with one specific group of disorders.

I. **Physician Orders for Life Sustaining Treatment (POLST):** A signed, designated physician order form that addresses a patient's wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

J. **Prehospital Emergency Medical Services (EMS) Personnel:** Persons who have been certified as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.

K. **Resuscitation: Intervention**(s) intended to restore cardiac activity and respirations, for example:

- Cardiopulmonary resuscitation (CPR)
- Defibrillation
- Drug therapy
- Other life saving measures

L. **Standardized Patient-Designated Directives:** Forms or medallion(s) that recognizes and accommodates patient's wish to limit prehospital treatment at home or the scene of an incident, in healthcare facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Attachment 1)
- Physician Orders for Life-Sustaining Treatment (POLST) (Attachment 2)
- State EMS Authority-Approved DNR Medallion (V.C.2.b)

M. **Supportive Measures:** Medical intervention(s) used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhagic control
- Oral hydration
- Glucose administration
- Pain control

N. **Valid DNR Order for Patients in a Licensed Health Care Facility:**

- A written document in the medical record with the patient's name and this statement "Do Not Resuscitate", "No Code", or "No CPR" that is signed and dated by a physician; or

- A verbal order to withhold resuscitation given by the patient's physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient's medical record; or
- POLST with DNR checked; or
- AHCD when the instructions state resuscitation should be withheld/discontinued.

O. **Valid DNR Order for Patients at a Location Other Than a Licensed Facility:**

- Fully executed California Emergency Medical Services Authority and the California Medical Association approved DNR form signed and dated by the patient's physician; or
- A Medic Alert bracelet inscribed "Do Not Resuscitate EMS"; or
- A Physician Orders for Life-Sustaining Treatment (POLST) form; or
- A written, signed order in the patient's medical record.

III. PURPOSE

To establish criteria for prehospital EMS personnel when they encounter patients with Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives.

IV. PRINCIPLES

A. The right of patients to refuse unwanted medical intervention is supported by California Statute.

B. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.

C. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.

D. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.

E. Photocopies of all the patient-designated directives are acceptable.

F. A conscious patient who is oriented to person, place, time and purpose may revoke their patient-designated directive at any time.

V. POLICY

A. General Procedures for EMS Personnel:

1. Confirm the patient is the person named in the patient-designated directive

2. Initiate BLS measures immediately on patient in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing measures outlined in Determination of Death in the Prehospital Setting Policy 570.20

3. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive

4. If the patient's condition deteriorates during transport, including Emergency 9-1-1 and Non-Emergency Inter-Facility Transfers (IFTs), and the patient has a valid DNR, transport the patient to the facility requested/designated by the physician or family member(s). If no facility is requested or designated then transport to the closest facility.

B. Documentation of a DNR incident shall include, but is not limited to, the following:

1. Check the "DNR" box on the electronic Patient Care Report (ePCR);

2. Describe the care given. Document the base hospital physician's name, if consulted, and the date of the DNR directive;

3. Note the removal of any invasive equipment;

4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the ePCR;

5. When possible, provide a copy of the AHCD and/or other patient-designated directive with the ePCR.

C. Directive-Specific Procedures

1. AHCD

a. A valid AHCD must be:

i. Completed by a competent person age 18 or older
ii. Signed, dated, and include the patient's name
iii. Signed by two witnesses or a notary public
iv. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility

b. If the situation allows, prehospital EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.

c. Base hospital contact is required for any AHCD instructions other than withholding resuscitation.

2. State EMS Authority approved DNR medallion(s)

a. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility

b. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are two (2) medallion providers approved in California:

i. Medic Alert Foundation

ii. Caring Advocates

c. If the medallion is engraved "DNR," treat in accordance with this policy

d. If the medallion is engraved "DNR/POLST" and the POLST is available, treat as indicated on the POLST.

e. If the medallion is engraved "DNR/POLST" and the POLST is **NOT AVAILABLE**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

a. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signature is necessary.

b. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.

c. Prehospital EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.

d. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

e. Contact the base hospital for direction in the event of any unusual circumstance.

4. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered and aid-in-dying drug:

a. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner (Exhibit B)." However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

b. There are no standardized "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation. If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:

   i. The document is identified as a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner."
   ii. Patient's name, signature and dated

c. Provide comfort measures (airway positioning, suctioning) and/or BLS airway/ventilation measures

d. Withhold resuscitative measures if patient is in cardiopulmonary arrest.

e. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to consult with their base hospital whenever possible.

f. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.

g. Obtain a copy of the final attestation and attach it with the EMS ePCR when possible.

Cross Reference Policies:
Policy 560.11 Documentation of Patient Contact
Policy 570.20 Determination of Death in Prehospital Setting
Policy 570.35 Refusal of EMS Service

Exhibit A
Physician Orders for Life-Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Exhibit B
Example of Final Attestation Form

FINAL ATTESTATION FORM

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, I _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potentially associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

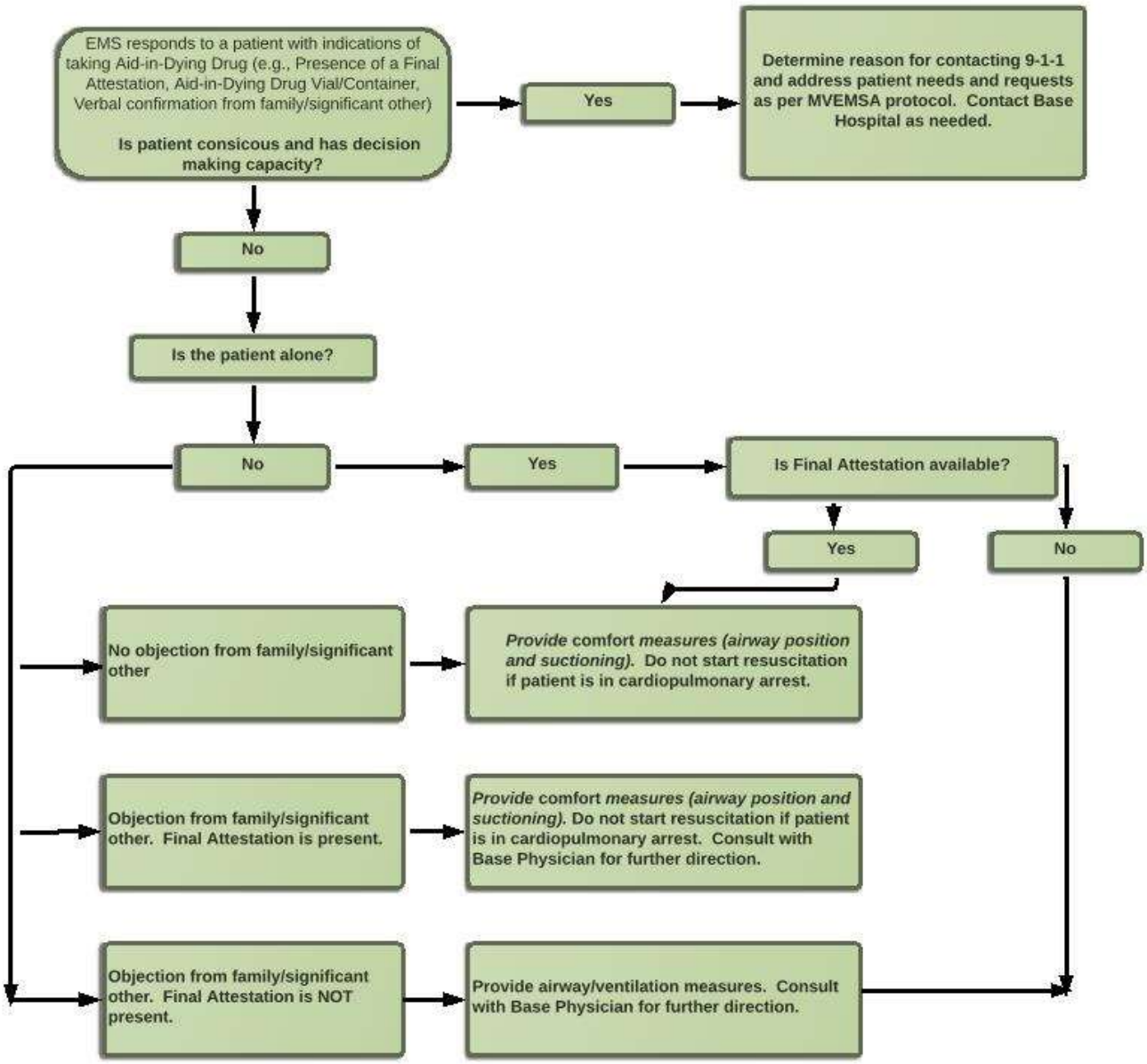
_____ I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: _____
Dated: _____
Time: _____

Exhibit C
End of Life Option Algorithm



APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 4/13/2005
SUPERSEDES:
REVISED: 03/2005
REVIEW DATE: 04/2010

PHYSICIAN ON SCENE

I. AUTHORITY

Health and Safety Code, Section 1797.220, and Title 22, California Code of Regulations, Section 100169.

II. PURPOSE

To provide direction for prehospital personnel when a physician is present on the scene of an EMS call.

III. POLICY

Prehospital ALS personnel shall accept direction from a physician at the scene of an EMS call only under the circumstances described below.

IV. PROCEDURE

A. If a physician wishes to direct the ALS care of a patient in the field and they are not recognized as a physician by EMS personnel, identification shall be requested. Identification should include a valid California Medical License and some form of identification that includes a picture (e.g. drivers license, hospital I.D.). Identification will not be required for calls originating at a physician's office, hospital or clinic.

B. For calls originating at a private physician's office, clinic, emergency department, or when a patient's own private physician is on-scene, ALS personnel may follow the attending physician's written direction and will not be required to make base hospital contact unless: 1) the physician's orders do not comply with Regionally approved policies or treatment guidelines, or 2) the physician's orders do not comply with Regionally approved ALS/BLS scope of practice, or 3) there is an unexpected development in route which would require base hospital contact. Any written directions given by the physician shall accompany the patient and a copy shall be attached to the Patient Care Record.

C. For calls originating at the scene of a medical emergency in which a physician is present who is not the patients private physician, or if the attending physician's orders described in paragraph B, do not comply with approved treatment guidelines or scope of practice, the physician shall either be 1) advised that prehospital personnel function under the direction of a base hospital physician and place them in contact with the base physician; or 2) presented with a "Note to Physician on Involvement with EMT IIs and EMT-P (Paramedic)" card endorsed by the California Medical Association and the State EMS Authority (see page 3 of 3); or 3) informed that he/she may assume medical direction if they are also willing to accompany the patient in the ambulance to the receiving hospital.

D. If the physician is not willing to accompany the patient and still wishes to direct the care, EMS personnel shall establish radio or telephone contact with the appropriate base hospital and explain the situation to the base hospital physician.

E. If the base hospital physician so directs, the ALS personnel may take medical direction from the private physician as long as that direction is consistent with their scope of practice. In this situation, the base hospital physician shall assume medical control upon the initiation of transport.

F. ALS personnel accepting appropriate direction from a private physician shall continue to follow Regional EMS policies, Treatment Guidelines, and Scope of Practice.

G. The private physician may choose to offer assistance with another pair of eyes, hands, or suggestions; but allow the ALS personnel to operate under the direction of the base hospital, or the appropriate policies and procedures.

H. At all times the private physician is to be treated with respect and courtesy. Utilize the base hospital physician to resolve any challenges that arise and file an Unusual Occurrence report with your employer liaison.

V. State of California - California Medical Association, Note To Physician on Involvement With EMT-IIs and EMT-Ps (Paramedic):

STATE OF CALIFORNIA EMSA &

CALIFORNIA
MEDICAL
ASSOCIATION

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-Is AND PARAMEDICS

A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy. If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the Good Samaritan Code@ (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104).
(over)

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the Sate of California, and, if requested, showing proof of identity, you may choose one of the following:

1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support tram remain under base hospital control; or,

2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,

3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures.

(Whenever possible, remain in contact with the base station physician)

(REV. 7/88) 88 49638 Provided by the Emergency Medical Services Authority

POLICY: 570.35
TITLE: Refusal of EMS Service

EFFECTIVE: 11/1/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

REFUSAL OF EMS SERVICE

I. AUTHORITY

In accordance with Section 100147, Title 22 of the California Code of Regulations, H&S Code 1797.220 & Chapter 5 1798, the medical director of the local EMS Agency shall establish and maintain medical control.

II DEFINITIONS

A. **EMS Personnel**: All EMTs and Paramedics providing care within the Emergency Medical Services System.

B. **Emancipated Minor** means a person who is under the age of 18 who is married or who is determined by a court of competent jurisdiction to be legally able to care for him or herself.

C. **Person** means any individual encountered by EMS Personnel who does not manifest any overt evidence of illness or injury – AND – refuses any assessment by Emergency Medical Personnel.

D. **Basic Life Support Ambulance** means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

E. **Patient** means any individual encountered by EMS Personnel who demonstrates any of the following.

1. Suspected illness or injury
2. Involved in an event with significant mechanism that could cause illness or injury
3. Requests care or evaluation.
4. An altered level of consciousness

F. **Patient Relationship** exists because of EMS being summoned and EMS personnel coming into contact with a patient.

G. **Refusal of Service** applies to those patients who are refusing any EMS services provided by EMS Personnel including assessment, treatment, or transportation.

H. **5150** is defined in code as, "A patient who is held against their will for evaluation under the authority of Welfare and Institution Code, Section 5150, because the patient is a danger to themselves, a danger to others and/or gravely disabled (i.e., unable to care for self). This is a written order placed by a law enforcement officer, County Mental Health Worker, or a health worker certified by the County to place an individual on a 5150 hold."

I. **5170** is defined in code as, "A person who is a danger to others or to him/herself, or gravely disabled as a result of inebriation. A peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the County, or other person designated by the County may, upon reasonable cause, take or cause to be taken, the person into civil protective custody and place him in a facility designated by the County and approved by the State Department of Alcohol and Drug Abuse as a facility for 72-hour treatment and evaluation of inebriates."

III PURPOSE

To provide direction and guidelines to EMS Personnel for patient-initiated refusal of service.

IV. POLICY

A. Any patient may decline all or part of assessment, treatments, or transportation by EMS Personnel if the following factors are present:

1. The patient has the ability to communicate a choice.
2. The patient has the ability to understand the relevant information.
3. The patient has the ability to appreciate the situation and its consequences.
4. The patient has the ability to reason rationally.
5. The patient is an emancipated minor or over the age of 18.

B. When it is determined that a patient has refused assessment, treatment, or transport by ambulance, EMS personnel shall complete a refusal of EMS service form as developed by their respective employer.

C. EMT's conducting the Refusal of Service/AMA process must be operating in an Agency approved BLS Tiered Response system.

Example narrative: REFUSAL OF CARE AND TRANSPORT: The patient decided to refuse care which consisted of (Specify Care) and/or transport to the hospital of their choice. The patient was found alert and oriented to person, place, time, and situation at time of refusal. Further, we discussed several items that are consistent with someone who may demonstrate decisional capacity, such as; 1) Communicated a choice = The patient actively declined treatment and/or transport in their own words, 2) Understood relevant information = The patient expressed in their own words the medical crisis at hand and risks/benefits of medical treatment after discussion with Paramedic, 3) Appreciated the situation = The patient described their view of their medical condition and, 4) Reasoning about treatment/transport options = The patient's criterion for making their decision appeared reasonable. The appropriate signature was obtained on MVEMSA refusal of service form for this patient.

V. PROCEDURE

A. In the event a patient is refusing EMS services the EMS personnel with the highest medical authority on scene shall attempt the following:

1. Obtain a history of the event and prior medical history including medications.
2. Perform a physical assessment to include a complete set of vital signs and ensure that there are no life or limb threatening injuries or illnesses that would place this patient's life in jeopardy if left untreated.
3. You must give the patient enough information about the decision they are making so that there is informed consent. You must be satisfied that the patient has understood the risk and options concerning their decision.
4. Explain in detail the Medical Miranda Card as defined below:.

Patient Refusal Rights and Information

You are refusing medical treatment and/or transport. Your health and safety are our primary concern, please remember the following:

1. Our evaluation and/or treatment is not a substitute for medical evaluation and treatment by a doctor. We advise you to see a doctor or go to a hospital emergency department.

2. Your condition may not seem as bad to you as it is. Without treatment, your condition or problem could become worse.

3. If you change your mind or your condition becomes worse, please don't hesitate to call us back, by dialing 911. We will do our best to help you.

4. Don't wait! When medical treatment is needed, it's usually better to get it right away.

SPECIAL CONDITIONS:

5. Your condition has been discussed with a doctor at the hospital by radio or telephone and the advice given to you has been issued or approved by the doctor.

6. FOR MINORS: Instruct the patient's legal guardian that in this situation they are acting on behalf of the patient, and they understand the above information regarding refusal of treatment or transport and accept responsibility for the patient.

5. If a Basic Life Support Ambulance encounters a patient as defined in this policy and does not have a suspected ALS complaint, the EMTs shall complete the refusal of care process as outlined. If the patient is suspected to have an ALS complaint and refuses treatment and transport the EMT shall request an ALS ambulance, Paramedic supervisor or Paramedic QRV to complete the Refusal of Service process

B. For patients that are refusing part or all the assessment, treatment, or transportation and who in the judgment of the EMS personnel, requires assessment, treatment, or transportation, consider the following.

1. Have your partner offer assessment, treatment, or transportation.

2. Contact a designated base hospital for assistance from the base hospital physician in further assessment of the patient. Communication with the base physician may require communication between the physician and patient.
3. For a patient meeting "trauma criteria," a designated Trauma Center will be contacted in all cases of patient refusal of assessment, treatment, or transportation.
4. If the patient is a danger to themselves or others or meets the definition of a 5150 or 5170 patient, contact law enforcement officials.

C. Complete and explain the refusal of EMS service form to the patient.

1. A signature should be obtained from the patient and a witness if possible.
2. If patient is a minor or incompetent adult, assure that the legal guardian is refusing treatment prior to allowing the refusal.

D. Each item described above shall be documented on the prehospital care report (PCR) and filed per individual EMS service provider policy.

E. Provider Agencies will use the elements listed below on the EMS Service Patient Refusal Form:

1. Patient's Name, Age, Date, Incident Number, and Incident Location
2. Criteria for refusing care
3. Acknowledgement of Information
4. Release of Liability
5. Location for patient's signature and date
6. Check box for "refused to sign"
7. Witness signature line
8. Form completed by, signature line, date, and ID number

POLICY: 924.00
TITLE: Amador County BLS Tiered Response System

EFFECTIVE: 04/01/2022
REVIEW: 04/2027
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Amador County BLS Tiered Response System

I. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.200

II DEFINITIONS

A. "Emergency Medical Dispatch" means a dispatch center that provides Emergency Medical Dispatch, including pre-arrival instructions, utilizing a card system approved by the EMS Agency Medical Director.

B. "Advanced Life Support Ambulance" means an emergency ambulance staffed with a minimum of one (1) Paramedic and one (1) Emergency Medical Technician (EMT)

C. "Basic Life Support Ambulance" means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III PURPOSE

To utilize Basic Life Support Ambulances in the 911 system for low acuity calls identified through the Emergency Medical Dispatch (EMD) process.

IV. POLICY

All Ambulance responses will be determined using the Medical Priority Dispatch System (MPDS) protocols and respond based on the level and mode of response approved by the Mountain Valley Emergency Medical Services Agency (MVEMSA) Medical Director.

V. PROCEDURE

A. MVEMSA authorized Emergency Medical Services Dispatch Center shall ensure that each request for ambulance service is managed in a manner consistent with established Agency policies, procedures, and the Medical Priority Dispatch System (MPDS) protocols.

B. A Basic Life Support Ambulance will be dispatched for service requests meeting the dispatch criteria using the MPDS and the Agency Medical Director approved level and mode of response.

C. Emergency Medical Technicians shall use the Mountain Valley Emergency Medical Services Agency approved policies, procedures, and protocols within their Scope of Practice to assess and treat patients when dispatched to a request for service. This shall include, but not be limited to documentation standards and Receiving Facility Radio Report.

D. If the patient assessment conducted by the Emergency Medical Technicians (Basic Life Support Ambulance) reveals a potentially unstable patient, the crew shall rendezvous with a paramedic resource (ALS Ambulance/ ALS Fire/Supervisor/QRV). If the time to rendezvous with a paramedic resource is greater than the estimated transport time to the closest receiving hospital, then the BLS crew shall transport to the closest receiving hospital. Transport mode, i.e., Code 2/3 is at the discretion of the transporting crew.

Potentially unstable adult patient:

- Cardiac Arrest
- Heart Rate < 50 or > 120
- Systolic Blood Pressure < 90mmHg
- Respiratory Rate > 24
- 02 sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate
- Any patient that meets trauma activation criteria per MVEMSA Policy
- 553.25 Trauma/Burn Triage and Patient Destination

Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.

1. Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
   - Tone
   - Interactiveness
   - Consolability
   - Look/gaze
   - Speech/cry

2. Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
   - Stridor
   - Wheezing
   - Grunting
   - Tripod positioning
   - Retractions
   - Nasal flaring
   - Apnea/gasping

3. Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
   - Pale
   - Mottled
   - Cyanotic

Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

E. If the patient refuses transport after assessment is completed, and/or any treatment provided, “Against Medical Advice” paperwork and process must be completed. Complete the process as outlined in MVEMSA policy 570.35 “Refusal of EMS Service.” ALS Fire shall NOT be requested specifically for the AMA process.

F. All transports involving the use of Basic Life Support Ambulance in the 911 system must be reviewed through the Quality Improvement Process at the ambulance provider level. Any case that needs further attention and review according to MVEMSA Policy 620.00, Unusual Occurrence Reporting shall be forwarded to the Quality Improvement Coordinator at MVEMSA.

G. The Emergency Medical Technician shall contact their immediate supervisor for any circumstances that may not be covered in this policy while responding to request for service, on scene of a request for service, and/or transporting to the receiving hospital.

POLICY: 944.10
TITLE: Mariposa County BLS Tiered Response System

EFFECTIVE: 07/01/2023
REVIEW: 07/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Mariposa County BLS Tiered Response System

I. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.200

II DEFINITIONS

A. "Emergency Medical Dispatch" means a dispatch center that provides Emergency Medical Dispatch, including pre-arrival instructions, utilizing a card system approved by the EMS Agency Medical Director.

B. "Advanced Life Support Ambulance" means an emergency ambulance staffed with a minimum of one (1) Paramedic and one (1) Emergency Medical Technician (EMT)

C. "Basic Life Support Ambulance" means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III PURPOSE

To utilize Basic Life Support Ambulances in the 911 system for low acuity calls identified through the Emergency Medical Dispatch (EMD) process.

IV. POLICY

All Ambulance responses will be determined using the Medical Priority Dispatch System (MPDS) protocols and respond based on the level and mode of response approved by the Mountain Counties Emergency Medical Services Agency (MCEMSA) Medical Director.

V. PROCEDURE

A. MCEMSA authorized Emergency Medical Services Dispatch Center shall ensure that each request for ambulance service is managed in a manner consistent with established Agency policies, procedures, and the Medical Priority Dispatch System (MPDS) protocols.

B. A Basic Life Support Ambulance will be dispatched for service requests meeting the dispatch criteria using the MPDS and the Agency Medical Director approved level and mode of response.

C. Emergency Medical Technicians shall use the Mountain Counties Emergency Medical Services Agency approved policies, procedures, and protocols within their Scope of Practice to assess and treat patients when dispatched to a request for service. This shall include, but not be limited to documentation standards and Receiving Facility Radio Report.

D. If the patient assessment conducted by the Emergency Medical Technicians (Basic Life Support Ambulance) reveals a potentially unstable patient, the crew shall rendezvous with a paramedic resource (ALS Ambulance/ ALS Fire/Supervisor/QRV). If the time to rendezvous with a paramedic resource is greater than the estimated transport time to the closest receiving hospital, then the BLS crew shall transport to the closest receiving hospital. Transport mode, i.e., Code 2/3 is at the discretion of the transporting crew.

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Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

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