



## SIERRA-SACRAMENTO VALLEY EMERGENCY MEDICAL SERVICES AGENCY

*Serving the counties of Placer, Yolo, Yuba, Sutter, Nevada, Colusa, Butte, Shasta, Tehama, Siskiyou*

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**DATE:** April 20, 2012

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

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

**SUBJECT:** S-SV EMS Agency Prehospital Care Policy Manual Update #48

### **EFFECTIVE DATE OF IMPLEMENTATION – June 1, 2012**

Enclosed is the **S-SV EMS Agency Policy Manual Update #48. Prior to the implementation date of these Policies/Protocols:**

- S-SV EMS approved prehospital service providers are responsible for distribution of these updated policies and protocols to their personnel. Prehospital service providers are also responsible for providing any necessary orientation to all BLS, LALS & ALS field personnel regarding the provisions and requirements of these new and/or updated policies and protocols.
- Base/Modified Base Hospital Medical Directors and Base/Modified Base Hospital Coordinators are responsible for providing orientation to emergency department physicians and MICN personnel.
- **The LALS (Advanced EMT) updated treatment protocols are not included with this update packet to avoid confusion. These protocols will be provided separately to the provider agencies that utilize Advanced EMT personnel as well as their base hospitals. These updated policies will also be posted and available on our website.**

Please advise all field and base/modified base hospital personnel that these new and/or updated S-SV EMS policies/protocols have the approval of S-SV EMS Agency committees, Regional Executive Director and the Medical Director. Therefore, all policies and procedures shall be strictly adhered to and are the basis for CQI activities.

All policies and protocols included in S-SV EMS Policy Manual Update #48 will be updated on the S-SV EMS website ([www.ssvems.com](http://www.ssvems.com)) prior to the June 1, 2012 date of implementation. Please feel free to contact the S-SV EMS Agency with any questions you may have regarding this update.

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REFERENCE	TITLE	ACTION	UPDATE COMMENTS
N/A	Table of Contents	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
200	Index II	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
202	S-SV EMS Agency Joint Powers Agreement	Replace	New JPA agreement for all 10 counties, effective February 1, 2011
213	S-SV EMS Agency Regional Trauma Quality Improvement Committee Bylaws	Replace	Updated committee bylaws
214	S-SV EMS Agency Aircraft Advisory/CQI Committee Bylaws	Add	New committee bylaws
375	EMT / Public Safety AED Program: Base Hospital Medical Control Requirements	Replace	Due for routine review. No changes
415-B	9-1-1 Response Time Criteria - Yolo County	Replace	Corrected name of Yocha Dehe Fire Department
415-C	9-1-1 Response Time Criteria - Sutter & Yuba Counties	Replace	Due for routine review. No changes
440	12-Lead EKG Program	Replace	Updated language regarding QI requirements, information that shall be printed on the 12 Lead EKG, and that copies of the EKG shall be available to the receiving physician upon EMS arrival
505-A	Hospital Capabilities	Replace	Added Enloe Medical Center and Mercy Medical Center Redding as Control Facilities
506	Cardiovascular "STEMI" Receiving Centers	Replace	Increase in EMS transported STEMI patient catchment area to 45 minutes. <b><u>Previously released for 1/1/2012 effective date</u></b>
700	Index VII	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
701	ALS Inventory	Replace	Updated IO language reflecting mandatory requirement for adult and pediatric patients. Updated minimum qty of epinephrine 1:1,000
702	Fireline Paramedic Inventory	Replace	Updated required concentration of midazolam to be consistent with ALS inventory
703	Limited Advanced Life Support (LALS) Inventory	Replace	Updated minimum qty of epinephrine 1:1,000
706	Equipment and Supply Shortages	Add	New policy providing direction to address equipment and supply shortages as the result of manufacturer or vendor issues
800	Index VIII	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
801	EMT Scope of Practice	Replace	Corrected policy title error on pages 3 & 5
823	Do Not Resuscitate	Replace	Updated language regarding S-SV EMS Approved DNR orders
844	ALS / LALS Transfer of Patient Care	Add	Clarified language regarding transfer of patient care from an AEMT or paramedic to an EMT partner
851	Treatment / Transport of Minors	Replace	Clarification on minors not requiring parental consent for EMS treatment. Removal of language regarding minor patients not requiring treatment or transport as this language is already in policy 850
860	Trauma Triage Criteria	Replace	Updated triage criteria to be consistent with 2011 CDC guidelines
872	EMT Administration of Epinephrine by Auto-Injector for Suspected Anaphylaxis &/or Severe Asthma	Replace	Due for routine review. No changes
890	Communication Failure	Replace	Added activated charcoal as a "Base/Modified Base Hospital Physician Order Only"
895	AED Treatment Guideline	<b>Remove</b>	Policy is no longer necessary, information is already included in Protocols C-1 and P-4
C-5	Return of Spontaneous Circulation (ROSC)	Replace	Updated fluid bolus and dopamine language to be consistent with AHA 2010 ECC guidelines
C-5 (LALS)	Return of Spontaneous Circulation (ROSC)	Replace	Updated fluid bolus language to be consistent with AHA 2010 ECC guidelines
C-8	Chest Pain or Suspected Symptoms of Cardiac Origin	Replace	Increase in EMS transported STEMI patient catchment area to 45 minutes. <b><i>Previously released for 1/1/2012 effective date</i></b>
R-1	Airway Obstruction	Replace	Addition of dose for nebulized epinephrine
R-1 (LALS)	Airway Obstruction	Replace	Addition of dose for nebulized epinephrine
R-2	Respiratory Arrest	Replace	Updated Naloxone language to be consistent with other treatment protocols
R-2 (LALS)	Respiratory Arrest	Replace	Updated Naloxone language to be consistent with other treatment protocols
M-3	Phenothiazine / Dystonic Reaction	Replace	Due for routine review. No changes

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
M-5	Ingestions and Overdoses	Replace	Addition of "Base / Modified Base Physician Order Only" for the administration of activated charcoal. Updated naloxone administration language for consistency with other protocols
M-5 (LALS)	Ingestions and Overdoses	Replace	Addition of "Base / Modified Base Physician Order Only" for the administration of activated charcoal. Updated naloxone administration language for consistency with other protocols
N-1	Altered Level of Consciousness	Replace	Updated Naloxone language to be consistent with other treatment protocols
N-1 (LALS)	Altered Level of Consciousness	Replace	Updated Naloxone language to be consistent with other treatment protocols
OB / G-1	Childbirth	Replace	Cleaned up flow of algorithm. Clarified suctioning of airway only if required and delay clamping the umbilical cord for 2 minutes for uncomplicated births not requiring resuscitation
OB / G-1 (LALS)	Childbirth	Replace	Cleaned up flow of algorithm. Clarified suctioning of airway only if required and delay clamping the umbilical cord for 2 minutes for uncomplicated births not requiring resuscitation
P-3	Apparent Life Threatening Event (ALTE) - ≤ 2 Years Old	Replace	Clarification on age (up to 3 years old). Moved pulse oximetry into BLS assessment / treatment box
P-3 (LALS)	Apparent Life Threatening Event (ALTE) - ≤ 2 Years Old	Replace	Clarification on age (up to 3 years old). Moved pulse oximetry into BLS assessment / treatment box
P-12	Respiratory Failure / Arrest	Replace	Updated protocol title. Added blood glucose check and updated naloxone administration language for consistency with other protocols
P-12 (LALS)	Respiratory Failure / Arrest	Replace	Updated protocol title. Added blood glucose check and updated naloxone administration language for consistency with other protocols
P-14	Respiratory Distress - Wheezing	Replace	Moved pulse oximetry into BLS assessment / treatment box. Added CPAP language in the BLS box for patients age 8 and above
P-14 (LALS)	Respiratory Distress - Wheezing	Replace	Moved pulse oximetry into BLS assessment / treatment box. Added CPAP language in the BLS box for patients age 8 and above
P-16	Respiratory Distress - Stridor	Replace	Title clarification. Moved pulse oximetry into BLS assessment / treatment box. Added 'consider nebulized saline' under ALS treatment. Updated dose of nebulized epinephrine
P-16 (LALS)	Respiratory Distress - Stridor	Replace	Title clarification. Moved pulse oximetry into BLS assessment / treatment box. Added 'consider nebulized saline' under LALS treatment. Updated dose of nebulized epinephrine

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
P-18	Allergic Reaction / Anaphylaxis	Replace	Minor language clean up related to SpO2
P-18 (LALS)	Allergic Reaction / Anaphylaxis	Replace	Minor language clean up related to SpO2
P-20	Shock	Replace	Minor language clean up. Moved pulse oximetry into BLS assessment / treatment box
P-20 (LALS)	Shock	Replace	Minor language clean up. Moved pulse oximetry into BLS assessment / treatment box
P-22	Overdose / Poisoning	Replace	Moved pulse oximetry into BLS assessment / treatment box. Updated naloxone administration language for consistency with other protocols
P-22 (LALS)	Overdose / Poisoning	Replace	Moved pulse oximetry into BLS assessment / treatment box. Updated naloxone administration language for consistency with other protocols
P-24	Altered Level of Consciousness	Replace	Cleaned up protocol algorithm flow. Combined neonate and pediatric dextrose information into a single box, Updated naloxone administration language for consistency with other protocols
P-24 (LALS)	Altered Level of Consciousness	Replace	Cleaned up protocol algorithm flow. Combined neonate and pediatric dextrose information into a single box, Updated naloxone administration language for consistency with other protocols
P-26	Seizure	Replace	Cleaned up protocol algorithm flow. Added status epilepticus and definition, clarified language regarding subsequent midazolam admin
P-26 (LALS)	Seizure	Replace	Cleaned up protocol algorithm flow. Added status epilepticus and definition, clarified language regarding subsequent midazolam admin
913	Paramedic Accreditation to Practice	Replace	Minor clarification regarding proof of employment and requirement for continuous PALS/PEPP certification
915	Mobile Intensive Care Nurse Authorization / Reauthorization	Replace	Updated language regarding authorization and reauthorization requirements

**SIERRA – SACRAMENTO VALLEY EMS AGENCY  
PREHOSPITAL CARE POLICY / PROTOCOL MANUAL**

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**Neurological**

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**Obstetrics / Gynecology**

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**Environmental**

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY

## LEMSA SECTION II

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- 220** S-SV EMS Agency Policy Actions

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**SECOND AMENDMENT AND RESTATED JOINT EXERCISE OF POWERS AGREEMENT FOR THE PURPOSE OF CONTINUING A REGIONAL EMERGENCY MEDICAL SERVICES AGENCY AND PROVIDING FOR THE CONTINUED IMPLEMENTATION, OPERATION AND MANAGEMENT OF AN EMERGENCY MEDICAL SERVICES SYSTEM IN THE COUNTIES OF BUTTE, COLUSA, NEVADA, PLACER, SHASTA, SISKIYOU, SUTTER, TEHAMA, YOLO AND YUBA, STATE OF CALIFORNIA**

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THIS AGREEMENT, dated for convenience, the First day of February, 2011, by and between the Counties of Butte, Colusa, Nevada, Placer, Shasta, Siskiyou, Sutter, Tehama, Yolo, and Yuba, each a political subdivision of the State of California (herein, collectively referred to as “Member Counties” or individually as “Member County”).

**RECITALS**

WHEREAS, under the provisions of the Government Code, State of California (Section 6500, et seq.), the parties hereto may jointly exercise powers common to all; and

WHEREAS, there now exists within the area of jurisdiction of the parties hereto, an urgent and demonstrated need for the continuation of a Regional EMS Agency and an Emergency Medical Services (EMS) program in order to continue and improve Emergency Medical Services and to jointly undertake necessary solutions; and

WHEREAS, the parties hereto desire to delineate Local EMS Agency responsibilities in accordance with the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (Section 1797, et seq. of the California Health and Safety Code) hereinafter called the “Act,” and participate in Joint Powers Agency hereafter established.

NOW, THEREFORE, in consideration of the mutual promises, covenants and conditions hereinafter contained, the parties hereto agree as follows:

## **ARTICLE I**

### **PURPOSE AND CREATION**

The purpose of this Agreement is to provide unified planning and coordination of a Regional Emergency Medical Services System by and through a Joint Powers Agency and for that agency to perform the duties and responsibilities of local EMS agency for the Member Counties in their ongoing operation and management of county emergency medical services systems.

There is hereby created pursuant to the Joint Exercise of Powers Act an agency to be known as the Sierra-Sacramento Valley Emergency Medical Services Agency, herein referred to as “Agency.” For the purpose specified in this Agreement, the Agency shall be an entity separate from the parties to this Agreement.

## **ARTICLE II**

### **TERM**

- A. This Agreement shall become effective as of the date upon which all member counties have approved it and shall continue in full force and effect until terminated by mutual agreement of the parties hereto. In the event that a county or counties withdraw from the Agency (“Withdrawing County”), as per the term and conditions set forth in ARTICLE VI of this Agreement; and, if the remaining Member Counties desire to continue the Agency, the Withdrawing County (or counties) shall be removed from the Agreement, and it shall not be necessary to cause a new agreement to be executed by the remaining counties.

- B. If all Member Counties agree to terminate this Agreement, any money or assets, except funded equipment in possession of the Agency for use under this Agreement, after payment of all liabilities, costs, expenses and charges incurred under this Agreement, shall be returned to the counties in proportion to their contributions determined as of the time of termination. All funded equipment shall be disposed of in a manner prescribed by the appropriate grantor Agency.

### **ARTICLE III**

#### **FUNDING**

A. Member County Contributions

As Member Counties, we acknowledge the need for stabilization of funding in order for the Agency to perform required duties. Each Member County shall provide the Agency with an annual base contribution of \$10,000. In addition to the base contribution, the Member Counties agree to provide the Agency with an additional contribution of 42 cents per capita, or as determined by the Agency board by Resolution. Member county's current population figures shall be based upon figures obtained from the Demographic Research Unit, Department of Finance, State of California.

The first payment of the total county contribution shall be based on the previous year's contribution and shall be due and payable no later than August 1. The second payment of the county contribution shall be based on current county population and shall be due and payable no later than February 1.

B. State Funding

The Agency shall annually apply for regional funding from the State Emergency Medical Services Authority. This shall include, but not be limited to, State general fund grants, Federal block grants and any special project grants.

## **ARTICLE IV**

### **GENERAL POWERS**

A. **Board of Directors**

1. The Agency shall be governed by a Board of Directors, herein referred to as “Board,” composed of ten voting members as follows: One (1) representative of the Board of Supervisors of each Member County. Each such JPA Board member shall be selected by and serve at the pleasure of the Member County’s Board of Supervisors represented by such representative.
2. Any Supervisor of a member county’s board may serve as an alternate. Such alternate shall vote only in place of their absent representative. Each member shall have an equal vote.
3. The Agency shall have a full or part-time California licensed physician and surgeon as Medical Director, who has substantial experience in the practice of emergency medicine, to provide medical control and to assume medical accountability throughout the planning, implementation and evaluation of the EMS System. Such physician shall act as the Medical Director of the local EMS agency pursuant to the

Act for member counties and counties with whom the Agency contracts with for such services.

4. The Agency shall employ a Regional Executive Director and fix his/her salary. He/She shall serve at the pleasure the Board of Directors. It shall be the responsibility of the Regional Executive Director to employ and discharge staff. Agency positions are established by the Board.
5. The Board of Directors of the Agency shall provide for its regular meetings. One meeting every other month shall be held. Special meetings may also be called if needed. One of the regular meetings shall be designated as the annual meeting at which time a review of the Joint Powers Agreement may take place. The annual meeting shall include the election of officers and other business as deemed necessary by the Board. The meetings shall be held in compliance with the Ralph M. Brown Act (Government Code, Section 54950 et seq.). Notice of regular meetings and the agenda shall be posted in a public location at least 72 hours in advance of said meetings.
6. The Regional Executive Director of the Agency shall cause to be kept minutes of the regular, adjourned regular and special meetings of the Board of Directors and shall, as soon as possible after each meeting, cause a copy of the minutes to be forwarded to each member and alternate of the Board.
7. A majority of the membership of the Board of Directors shall constitute a quorum for the transaction of business, except that less than a quorum may adjourn from

time to time. The affirmative vote of a majority of the members shall be required for the approval of any motion/resolution as to which action of the Board is required.

8. Any vacancy of a regular or alternate member of the Board shall be filled by the authority which made the appointment.
9. Members of the Board shall serve without compensation, but shall receive reimbursement from the Agency for actual and necessary expenses incurred when on official duty for the Agency (including a stipend and mileage for travel to and from meetings of the Board, unless otherwise provided by the member's county). No member of the Board may be compensated for any service to the Agency except as provided in this section. Nothing herein shall be construed to prohibit member counties from compensating their Members or alternates for services on the Board.
10. Reimbursement for expenses shall be made by the Agency upon submittal of proper documentation.

**B. Other Officers**

The Treasurer and Auditor of the County of Placer are designated as Treasurer and Auditor respectively by each member county to act on behalf of the Agency and to be responsible for fiscal management under the terms of this Agreement. Said county shall be entitled to receive project indirect costs as agreed upon between the Board and Placer County.

**C. Contracts**

In order to achieve the purpose of this Agreement, the Agency may make and enter into contracts, including contracts with public and private organizations and individuals, employ agents and employees, secure necessary services and materials in accordance with grant

awards, and sue and be sued in its own name. No contract of the Agency may extend beyond the term of this Agreement and any renewals thereof. As set forth in Section IV.D, no party to this Agreement shall be responsible for any debt or obligation of the Agency.

D. Liability

No expense shall be incurred in excess of available funds for the establishment and operation of the Agency established pursuant to the Joint Exercise of Powers Act without prior written approval of the Member Counties. The Agency shall indemnify, defend and hold harmless each of the Member Counties and their authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages and /or liability arising from the Agency's acts, errors or omissions and for any costs or expenses incurred by the Member County(ies) on account of any claim therefore, except where such indemnification is prohibited by law. The Agency shall obtain liability insurance containing limits of liability in such amount as the Board of Directors determines is necessary to cover the risk of liability incurred by the activities of the Agency. The Agency shall cover all employees with Workers' Compensation Insurance. The debts and obligations of the Agency are not and shall not become debts or obligations of any of the parties to this Agreement. No party to this Agreement shall be responsible for any debt or obligation of the Agency.

E. Grants

The Agency may, with Board approval apply for and receive State, Federal, local government and private organizational grants, and may receive contributions or donations from any

source for the implementation of the purposes of the Agency as stated herein. The Agency may earn and expend income for activities undertaken for its purpose.

F. Bylaws

The Board of Directors of the Agency shall adopt bylaws for the governing of the Agency and for the conducting of the business of the Board. Such bylaws shall make provision for an annual independent audit. Such bylaws shall also provide for the operation of Agency programs including the compensation and privileges of the employees of the Agency. Such bylaws shall also provide for an annual report of the activities to be made to the Board of Supervisors of the counties which are parties thereto, which report shall include a specific itemization of all revenues and expenditures of the Agency, including the annual audit report, an itemization of employee benefits paid and all expenses that have been allowed to employees of the Agency. The board of Directors shall elect a Chairperson and Vice-Chairperson to serve for one year and shall also appoint a Secretary who need not be a member of the Board.

G. Governing Law

Pursuant to Section 6509 of the Government Code, the powers of the Agency are subject to the restrictions upon the manner of exercising the power of the County of Placer.

**ARTICLE V**

**REGIONAL EMERGENCY MEDICAL SERVICES SYSTEM ADMINISTRATION**

A. Agency Designation

The Agency is designated as the Local EMS Agency by each signatory to this Agreement.

B. Agency Authorization

The execution of this Agreement acts as a delegation to the Agency by each signatory of all the California Health and Safety code, Division 2.5 functions, and the Agency shall act as the Local EMS Agency as to each function.

C. Designated Agency Functions

Within the territorial jurisdiction of each county signatory to this Agreement, the Agency shall perform the functions set forth in California Health and Safety Code, Division 2.5 (Cal H&S Code Section 1797 et seq., as currently written, or as may be amended, as well as the following:

1. The Agency may develop a schedule of fees for testing and certification in an amount sufficient to cover the actual cost of administering the certification process.
2. The Agency shall provide an organizational and committee structure which fosters interagency coordination and maintains an effective working relationship between individuals and groups.
3. The Agency shall provide liaison with county Emergency Medical Care Committees and providers to plan effective program variations which meets specific county provider and patient needs.
4. The Agency shall periodically reassess facilities to assure that listed treatment capability is current and modifications of triage and treatment guidelines reflect current medical practice.
5. The Agency shall perform legislative activities on behalf of the member counties at the state and local levels.

6. The Agency shall research availability of funds, institute applications where appropriate, and manage budgets in accordance with regional policies and specific requirements of funding sources.
7. The Agency shall facilitate intercounty and interregional response and transport of patients.
8. The Agency shall comply with all other relevant requirements as stated in the Act.
9. The Agency may contract with any organization to provide any relevant service of function authorized by the Act.
10. The Agency may have other powers and responsibility authorized by the counties.

## **ARTICLE VI**

### **WITHDRAWAL**

- A. Any signatory to this Agreement may withdraw by giving written notice to all the other signatories a minimum of six (6) months prior to the end of the fiscal year in which such notice is given. Withdrawal shall be effective at the end of the fiscal year unless otherwise specified in this Agreement.
- B. Equipment and Funds. Upon withdrawal of a Member County, any money or assets, including funded equipment in possession of the Agency for use under this Agreement shall remain with the Agency, except that the Board of Directors in its sole discretion, may permit a Withdrawing County to retain emergency medical care equipment secured through the Agency if the Board determines that such equipment is needed for the medical care of residents of the Withdrawing County. For situations arising that are not covered by the above guidelines, the Withdrawing County and the Board of Directors of the Agency may

enter into a contract settling the terms and conditions of withdrawal. A Withdrawing County shall not be entitled to any further distribution of Agency property or funds.

- C. Payment of Other Postemployment Benefits (OPEB) arising during the term of this JPA. The Member Counties agree that if a member County withdraws from the JPA, there will be a subsequent increase in OPEB liability for the other member Counties. As a result, a Withdrawing County shall, prior to withdrawal from the JPA, pay an amount calculated by taking the Agency's OPEB accrual for the most recent fiscal year, determining the Withdrawing County's pro-rata share based on population, and multiplying that share by the number of years that County has been a member of the JPA (partial years shall be rounded up to the next full number).

## **ARTICLE VII**

### **FISCAL YEAR**

For the purposes of this Agreement, the term "fiscal year" shall mean the period from July 1 to and including the following June 30<sup>th</sup>.

## **ARTICLE VIII**

### **CLAIMS**

All claims against the Agency including but not limited to claims by public officers and employees for fees, salaries, wages, mileage or other expenses, shall be filed within the time and in the manner specified in Chapter 2 (commencing with Section 910) of Part 3, Division 3.6 of Title 1 of the Government Code or in accordance with claims procedures approved by the Auditor – Controller of the Agency and established by the Board of Directors pursuant to Chapter 5 (commencing with Section 930) or Chapter 6 (commencing with Section 935) of said Part 3 of the

Government Code. The Board of Directors shall adopt a regulation requiring that all claims shall be so filed.

## **ARTICLE IX**

### **ALLOWANCE OF CLAIMS BY AUDITOR-CONTROLLER**

- A. The Auditor-Controller of Agency shall audit and allow or reject claims based on the budget and without the prior approval of the Board of Directors in any of the following cases:
1. Expenditures which have been authorized by purchase orders issued by an office of the Agency authorized and approved by the Board of Directors to make such purchases.
  2. The Auditor-Controller shall require the certificate of the requisitioning or receiving officer that the articles or services have been received or contracted for in accordance with the prior authorization of the Board.

## **ARTICLE X – ADDITIONAL PROVISIONS**

- A. This Agreement supersedes the Agreement of February 11, 1992, by and between the counties of Nevada, Placer, Sutter, Yolo and Yuba and all forerunners and amendments thereof. All rights, duties, liabilities, obligations and assets of the Sierra-Sacramento Valley Emergency Medical Services Agency pursuant to said Agreement are hereby assumed by the Sierra-Sacramento Valley Emergency Medical Services Agency pursuant to said Agreements are hereby ratified and confirmed. It is not the purpose of this Agreement to do away with the Sierra-Sacramento Valley Emergency Medical Services Agency, but rather to amend its powers, and place it in compliance with the requirements as stated in Part 1 of Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

B. Performance of Functions by County. Agency shall be the sole Local Emergency Management Service Agency for each and every Member County, and shall perform the services enumerated in this agreement. However, Agency and the Member County may enter into such contracts allowing the Member County to perform any function or functions delegated to Agency by this Agreement at the time of its signing.

C. This Agreement may be amended at any time by the mutual agreement of the parties hereto.

**COUNTY OF PLACER**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF YOLO**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF YUBA**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF SUTTER**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF NEVADA**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF COLUSA**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF BUTTE**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF SHASTA**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF SISKIYOU**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**COUNTY OF TEHAMA**

SIGNATURE ON FILE  
Chairman \_\_\_\_\_ Date  
Board of Supervisors

**APPROVAL AS TO FORM**

SIGNATURE ON FILE  
Brian Wirtz \_\_\_\_\_ Date  
Counsel for JPA Governing Board of  
Directors

**APPROVAL AS TO FORM**

SIGNATURE ON FILE  
Arthur J. Wylene \_\_\_\_\_ Date  
Assistant County Counsel  
County of Tehama

**SIERRA-SACRAMENTO VALLEY**  
**EMERGENCY MEDICAL SERVICES AGENCY**

**REGIONAL TRAUMA QUALITY IMPROVEMENT COMMITTEE**  
**BYLAWS**

**I. NAME**

This committee shall be referred to as the Regional Trauma Quality Improvement Committee, hereinafter referred to as the "Committee".

**II. IMPLEMENTATION AUTHORITY**

- A. The Committee is established by the Sierra-Sacramento Valley Emergency Services Agency ("AGENCY"). The AGENCY is a Multi-County Joint Powers Agency ("JPA") responsible for oversight of the EMS / Trauma Systems in a ten-county region.
- B. The RTQI Committee is created pursuant to the requirements of California Code of Regulations, Title 22, Division 9, Chapter 7 - Trauma Care Systems and California Health and Safety Code, Chapter 6, Article 2.5, Regional Trauma Systems

**III. DEFINITIONS**

"Regional Trauma Quality Improvement" refers to methods of evaluation that are composed of structure, process and outcome evaluations. These methods of evaluation focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate those causes and take steps to correct the process. Excellence in performance and delivery of care is also recognized.

**IV. STATEMENT OF PURPOSE**

- A. This confidential Regional Trauma Quality Improvement Committee is established by the S-SV EMS Agency as the primary avenue for trauma system quality improvement review.
- B. Promote region-wide standardization of trauma care quality improvement.
- C. Monitor, evaluate and report on quality of trauma care in relation to prehospital / hospital training and care, including compliance with laws, regulations, policies and procedures as well as recommended revisions and/or corrective action as necessary.
- D. Establish indicators and modify them as necessary.

- E. Review potential problem trauma cases and system issues identified via the trauma system registry.
- F. Monitor the process and outcome of trauma patient care in the S-SV EMS region.
- G. Make recommendations for educational activities and/or policy revisions based upon quality review activities to the appropriate S-SV EMS Agency committee.

## **V. DUTIES**

- A. Participate with AGENCY in monitoring, collecting data and evaluating state required and optional Trauma System indicators within the AGENCY'S jurisdiction.
- B. Collaborate with AGENCY in collecting data, monitoring and evaluating locally identified indicators.
- C. Re-evaluate, expand upon and revise (annually, or as needed) locally developed indicators used by the COMMITTEE for Trauma quality improvement.
- D. The scope of review conducted by the Committee includes trauma patient care in the S-SV EMS Region and transfer of patients to other hospitals or designated trauma centers.
  - 1. Trauma patient care from time of injury (prehospital) through rehabilitation.
- E. All patient records and other confidential materials will be returned to the AGENCY at the end of the meeting.

## **VI. MEMBERSHIP**

VOTING MEMBERSHIP will include the following representatives from the AGENCY'S region:

- A. One Medical Director (or designee) from each designated trauma center within the S-SV EMS Region.
- B. One trauma physician from the Level I trauma center at UCDCM.
- C. One trauma program nurse manager / coordinator from each designated trauma center within the S-SV EMS Region.
- D. One trauma program nurse manager / coordinator from the Level I trauma center at UCDCM.

In consultation and in consensus, each member shall have an alternate available to assume the member's responsibilities in their absence.

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

## **VII. OFFICERS**

The COMMITTEE shall elect a Chair and a Vice-Chair.

## **VIII. TERMS**

- A. Officers shall be elected by the COMMITTEE for yearly terms commencing July 1 through June 30.
- B. If the Chair's position is vacated prior to the term's end, the Vice-Chair will assume the Chair's duties for the remainder of the term and a new Vice-Chair will be elected.
- C. If the Vice-Chair's position is vacated prior to the term's end, a replacement will be elected.
- D. Members shall serve at the will of the COMMITTEE, or until removed, resigned or replaced.
- E. Members who are unable to attend a regularly scheduled meeting should notify the AGENCY of their absence prior to the meeting and should attempt to send an alternate in their place.
  - 1. Members who are absent for more than two regularly scheduled meetings within a calendar year may be removed and replaced with another representative from the same category of representation.

## **IX. MEETINGS, VOTING, QUORUM**

- A. Meetings shall be held on a quarterly basis, no less than three (3) times in a calendar year. Meeting dates and times to be set or modified as agreed to by COMMITTEE.
- B. Special meetings may be called by the Agency or the Chairperson, as appropriate, or upon written request of a majority of the COMMITTEE members.
- C. A quorum to conduct business shall consist of a minimum of five (5) eligible voting members.

- D. The Chair will preside over meetings and participate in the preparation of the agenda.
- E. Meetings will be held in a fair and professional manner.
- F. The COMMITTEE shall operate under commonly accepted parliamentary procedures and Robert's Rules of Order shall govern the conduct of meetings when applicable.
- G. The AGENCY will be responsible for preparing the agenda, taking and maintaining the minutes.

**X. AMENDMENT OF BYLAWS**

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

**XI. CONFLICT OF INTEREST**

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

**XII. CONFIDENTIALITY**

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

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

**XIII. EFFECTIVE DATE**

These Bylaws shall be effective upon approval by the COMMITTEE.

Approved: SIGNATURE ON FILE Date: 1/13/2012

**SIERRA-SACRAMENTO VALLEY**  
**EMERGENCY MEDICAL SERVICES AGENCY**

**AIRCRAFT ADVISORY/CQI COMMITTEE**  
**BYLAWS**

**I. NAME**

This committee shall be referred to as the AIRCRAFT ADVISORY COMMITTEE, hereinafter referred to as the "COMMITTEE".

**II. IMPLEMENTATION AUTHORITY**

- A. The COMMITTEE is established by the Sierra-Sacramento Valley Emergency Services Agency ("AGENCY"). The AGENCY is a Multi-County Joint Powers Agency ("JPA") responsible to receive base hospital and service provider input and direction specific to prehospital medical care in the JPA region.
- B. The COMMITTEE is created pursuant to the requirements of *California Code of Regulations, Title 22, Division 9, Chapters 8-Prehospital EMS Aircraft Regulations & 12-EMS System Quality Improvement* and *California Health and Safety Code, Section 1157.7*

**III. DEFINITIONS**

"Emergency Medical Services System Quality Improvement" (or EMS QI) refers to methods of evaluation that are composed of structure, process and outcome evaluations. These methods of evaluation focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate those causes and take steps to correct the process. Excellence in performance and delivery of care is also recognized.

**IV. STATEMENT OF PURPOSE**

- A. To promote region-wide standardization of prehospital EMS Aircraft continuous quality improvement.
- B. To monitor, evaluate and report on quality of prehospital training, care and transportation, including compliance with laws, regulations, policies and procedures as well as recommended revisions and/or corrective action as necessary.
- C. To make recommendations specific to EMS provider, hospital and AGENCY data collection and dissemination.

## **V. DUTIES**

- A. Participate with AGENCY in monitoring, collecting data and evaluating state required and optional EMS System indicators from the EMS providers and hospitals within the AGENCY'S jurisdiction.
- B. Collaborate with AGENCY in collecting data, monitoring and evaluating locally identified indicators.
- C. Re-evaluate, expand upon and revise (annually, or as needed) locally developed indicators used by the COMMITTEE for EMS quality improvement.
- D. AGENCY will provide a follow-up status report to the COMMITTEE on all cases presented until the CQI loop is closed for the case.
- E. All patient records and other confidential materials will be returned to the AGENCY at the end of the meeting.

## **VI. MEMBERSHIP**

VOTING MEMBERSHIP will include the following representatives from the AGENCY'S region:

- A. One Air Ambulance quality improvement representative from each of the Air Ambulance providers in the AGENCY's region.
- B. One ALS Air Rescue quality improvement representative from each of the Air Rescue providers in the AGENCY's region.
- C. One Level I or Level II Trauma Hospital physician or ED nursing quality improvement representative
- D. One Level III or Level IV Trauma Hospital physician or ED nursing quality improvement representative.
- E. One base hospital, or modified base hospital ED physician or ED RN quality improvement representative.
- F. One representative from each Agency approved helicopter dispatch center, CAL FIRE and SHASCOM

G. One (1) public ALS service provider Paramedic representative and one (1) private ALS service provider Paramedic representative, who actively practice in the field, from the following two S-SV EMS Region county groups:

- Colusa, Nevada, Placer, Sutter, Yolo and Yuba counties
- Butte, Shasta, Siskiyou and Tehama counties

A minimum of one primary and one alternate physician must serve on the committee.

Each member shall have an alternate available to assume the member's responsibilities in their absence.

Prehospital EMS Aircraft provider and Dispatch Center committee members will be appointed by their respective agencies. All other members will be appointed by the AGENCY in a fair and equitable way from a group of interested and qualified candidates in such a manner to ensure adequate representation of the counties and disciplines of the EMS system.

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

## **VII. OFFICERS**

The COMMITTEE shall elect a Chair and a Vice-Chair.

## **VIII. TERMS**

- A. Officers shall be elected by the COMMITTEE for yearly terms commencing July 1 through June 30.
- B. If the Chair's position is vacated prior to the term's end, the Vice-Chair will assume the Chair's duties for the remainder of the term and a new Vice-Chair will be elected.
- C. If the Vice-Chair's position is vacated prior to the term's end, a replacement will be elected.
- D. Members shall serve at the will of the COMMITTEE, or until removed, resigned or replaced.
- E. Members who are unable to attend a regularly scheduled meeting should notify the AGENCY of their absence prior to the meeting and should attempt to send an alternate in their place.

- a. Agency appointed members who are absent for more than two regularly scheduled meetings within a calendar year may be removed and replaced with another representative from the same category of representation.
- b. For Prehospital EMS Aircraft provider and Dispatch Center appointed members who are absent for more than two regularly scheduled meetings with a calendar year, the AGENCY will contact the individual provider and request they appoint another member who can fulfill the role.

#### **IX. MEETINGS, VOTING, QUORUM**

- A. Meetings shall be held on a quarterly basis, no less than three (3) times in a calendar year. Meeting dates and times to be set or modified as agreed to by COMMITTEE.
- B. Special meetings may be called by the Agency or the Chairperson, as appropriate, or upon written request of a majority of the COMMITTEE members.
- C. A quorum to conduct business shall consist of a minimum of five (5) eligible voting members.
- D. The Chair will preside over meetings and participate in the preparation of the agenda.
- E. Meetings will be held in a fair and professional manner.
- F. The COMMITTEE shall operate under commonly accepted parliamentary procedures and Robert's Rules of Order shall govern the conduct of meetings when applicable.
- G. The AGENCY will be responsible for preparing the agenda, taking and maintaining the minutes.

#### **X. AMENDMENT OF BYLAWS**

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

#### **XI. CONFLICT OF INTEREST**

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

#### **XII. CONFIDENTIALITY**

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The COMMITTEE's 1157.7

business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.

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

**XIII. EFFECTIVE DATE**

These Bylaws shall be effective upon approval by the COMMITTEE.

Approved: SIGNATURE ON FILE Date: 1/23/2012

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 375

## **SUBJECT: EMT / PUBLIC SAFETY AED PROGRAM: BASE HOSPITAL MEDICAL CONTROL REQUIREMENTS**

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### **PURPOSE:**

To establish the requirements and standards for medical control of authorized EMT / Public Safety automatic external defibrillation (AED) service providers.

### **AUTHORITY:**

California Health and Safety Code, Division 2.5, Sections 1797.200, 1798, 1798.2, 1798.102 and 1798.104.

California Code of Regulations, Title 22, Chapters 1.5 and 2

### **PROCEDURE:**

Medical Control:

The EMT/Public Safety AED designated base hospital shall provide medical control for authorized EMT/Public Safety AED service providers. This shall include the following:

- A. Appointment of a physician medical director.
- B. Appointment of a registered nurse coordinator.
- C. Submit letter of support to the EMS Agency for new AED service providers within their service area.
- D. Review all Patient Care Report (PCR) forms of all EMT/Public Safety AED contacts for compliance to S-SV policy/procedure. Follow-up action will be referred to the AED service provider and the S-SV EMS Agency, as needed.
- E. Provide assistance with periodic training, structured clinical experience, and continuous quality improvement, in compliance with S-SV EMS policy.

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**Effective Date: 06/01/2012**

**Date last Reviewed / Revised: 04/12**

**Next Review Date: 04/2015**

**Page 1 of 2**

**Approved:**

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**SIGNATURE ON FILE**  
**S-SV EMS Medical Director**

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**SIGNATURE ON FILE**  
**S-SV EMS Regional Executive Director**

**SUBJECT: EMT / PUBLIC SAFETY AED PROGRAM:  
BASE HOSPITAL MEDICAL CONTROL REQUIREMENTS**

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**CROSS REFERENCES:**

Policy and Procedure Manual

EMT/Public Safety AED Program: Service Provider Requirements and Responsibilities, Reference No. 474

EMT/Public Safety AED Program: Application and Approval Process, Reference No. 475

Continuous Quality Improvement Program: Reference No. 620

**SIERRA-SACRAMENTO VALLEY EMS AGENCY  
PROGRAM POLICY**

**REFERENCE NO. 415-B**

**SUBJECT: 9-1-1 RESPONSE TIME CRITERIA –YOLO COUNTY**

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<b>RESPONSE TIME STANDARDS</b>	
<b>YOLO COUNTY</b>	
<b>AMERICAN MEDICAL RESPONSE (AMR)</b>	
<b>City of Davis, UC Davis</b>	8 minutes 90% of the time
<b>Woodland</b>	8 minutes 90% of the time
<b>West Sacramento</b>	8 minutes 90% of the time
<b>West Plainfield, Willow Oak Fire, and Yolo Fire</b>	15 minutes 90% of the time
<b>Winters</b>	18 minutes 90% of the time
<b>Elkhorn Fire, Knights Landing, Madison, Zamora Fire, Esparto Fire, Dunnigan Fire, and Clarksburg Fire</b>	20 Minutes 90% of the time
<b>Capay Fire, and Yocha Dehe Fire</b>	25 minutes 90% of the time
<b>Yolo County – Wilderness</b>	As soon as possible

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**Next Review Date: 10/2012**  
**Approved:**

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**SIERRA-SACRAMENTO VALLEY EMS AGENCY  
PROGRAM POLICY**

**REFERENCE NO. 415-C**

**SUBJECT: 9-1-1 RESPONSE TIME CRITERIA – SUTTER & YUBA COUNTY**

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<b>RESPONSE TIME STANDARDS</b>	
<b>SUTTER &amp; YUBA COUNTY</b>	
<b>BI-COUNTY AMBULANCE</b>	
<b>Yuba City</b>	8 minutes 90% of the time
<b>Marysville</b>	8 minutes 90% of the time
<b>Linda</b>	10 minutes 90% of the time
<b>Olivehurst</b>	10 minutes 90% of the time
<b>Rural – Sutter County</b>	20 minutes 90% of the time
<b>Rural – Yuba County</b>	20 minutes 90% of the time
<b>Bi-County - Wilderness</b>	As soon as possible
<b>BEALE AIR FORCE BASE</b>	
<b>Beale AFB</b>	8 minutes 90% of the time
<b>Beale – Wilderness</b>	ASAP

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 440

## **SUBJECT: 12-LEAD EKG PROGRAM**

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### **PURPOSE**

To establish the requirements and responsibilities for S-SV EMS approved LALS and ALS prehospital provider agencies to perform 12-Lead EKGs in the prehospital setting.

### **AUTHORITY**

California Health & Safety Code, Division 2.5, Sections: 1797.200, 1797.204, 1797.206, 1797.214, 1797.218, 1797.220, 1798.2, 1798.102, 1798.170

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

### **POLICY**

LALS and ALS provider agencies wanting to perform 12-Lead EKGs must submit to the S-SV EMS Agency for approval at least 30 days prior to the implementation of the program the following:

#### **A. 12-LEAD EKG TRAINING PROGRAM CURRICULUM**

A paramedic or advanced EMT authorized to perform 12-Lead EKGs must complete a minimum four (4) hour training program. The curriculum shall include:

1. Patient inclusion criteria
2. Anatomy
3. Basic electrophysiology
4. Leads and lead placement
5. Technical and protocol considerations

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**SUBJECT: 12-LEAD EKG PROGRAM**

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**B. CONTINUOUS QUALITY IMPROVEMENT PLAN**

1. Data Collection - Data shall be collected on each 12-Lead EKG performed. The data collected shall include at a minimum:
  - a. A copy of the 12-Lead EKG, including printed patient name as indicated in the procedure section below
  - b. Date and time of the call
  - c. Crew member names
  - d. Unit number
  - e. EKG Device number (ID number assigned to 12-Lead EKG by machine)
  - f. Hospital destination (if applicable)
  - g. Information on whether or not the EKG was transmitted to the base/modified base hospital and/or STEMI Receiving Center and any transmission issues identified
  
2. Data Reporting - The provider agency is responsible for submitting 12-Lead EKG data to the EMS Agency, as requested, to assist in the ongoing evaluation of the S-SV EMS STEMI System and other CQI processes.

**PROCEDURE**

- A. Indications: Utilization of S-SV EMS Agency Chest Pain or Suspected Symptoms of Cardiac Origin treatment protocol, (Reference No. C-8).
  
- B. All 12-Lead EKG's performed shall include, at a minimum, the patient's last name and first initial that is input into the monitor and printed on the EKG. In instances where the EKG is transmitted, this patient identification information shall be entered prior to transmission.
  
- C. Copies of all prehospital 12-Lead EKGs performed shall be available to the receiving hospital physician for review immediately upon EMS arrival and shall be left with the patient at the receiving facility at time of patient delivery.
  
- D. Copies of all prehospital 12-Lead EKGs performed shall be attached to the ePCR and become part of the patient's medical record.

**CROSS REFERENCES**

Prehospital Care Policy Manual

Cardiovascular STEMI Receiving Centers, Reference No. 506

Chest Pain or Suspected Symptoms of Cardiac Origin, Reference No. C-8



# SIERRA SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

Updated 06-2012

**SUBJECT: S-SV EMS BASE / RECEIVING HOSPITALS**

**REFERENCE NO. 505-A**

Hospital Name	County	Base Mod. Base Receiving	Level I / II Trauma Center	Level III Trauma Center	Level IV Trauma Center	Labor and Delivery	Pediatric Trauma Center	Burn Receiving Center	STEMI Receiving Center	Stroke Receiving Center
Biggs Gridley Memorial Hospital	Butte	Receiving			X					
Enloe Medical Center	Butte	Base	X			X			X	X
Feather River Hospital	Butte	Base				X				
Oroville Hospital	Butte	Base		X		X				X
Colusa Regional Medical Center	Colusa	Modified Base			X	X				
Sierra Nevada Memorial Hospital	Nevada	Modified Base				X				X
Tahoe Forest Hospital	Nevada	Modified Base				X				
Kaiser Roseville Medical Center	Placer	Modified Base				X			X	X
Sutter Auburn Faith Hospital	Placer	Modified Base								X
Sutter Roseville Medical Center	Placer	Base	X			X			X	X
Kaiser North Sacramento	Sacramento	Receiving								X
Kaiser South Sacramento	Sacramento	Receiving	X			X				X
Mercy General Hospital	Sacramento	Receiving				X			X	X
Mercy Hospital Folsom	Sacramento	Receiving				X				
Mercy San Juan Medical Center	Sacramento	Base	X			X			X	X
Methodist Hospital	Sacramento	Receiving				X				X
Sutter General Hospital	Sacramento	Receiving								X
Sutter Memorial Hospital	Sacramento	Receiving				X			X	X
UC Davis Medical Center	Sacramento	Base	X			X	X	X	X	X
Fairchild Medical Center	Siskiyou	Base			X	X				
Mercy Medical Center Mt. Shasta	Siskiyou	Base		X		X				
Mayers Memorial Hospital	Shasta	Base			X	X				
Mercy Medical Center Redding	Shasta	Base	X			X			X	X
Shasta Regional Medical Center	Shasta	Base		X					X	X



# SIERRA SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

Updated 06-2012

**SUBJECT: S-SV EMS BASE / RECEIVING HOSPITALS**

**REFERENCE NO. 505-A**

Hospital Name	County	Base Mod. Base Receiving	Level I / II Trauma Center	Level III Trauma Center	Level IV Trauma Center	Labor and Delivery	Pediatric Trauma Center	Burn Receiving Center	STEMI Receiving Center	Stroke Receiving Center
Fremont Medical Center - L&D	Sutter	L & D Only				X				
St. Elizabeth Community Hospital	Tehama	Base		X		X				
Sutter Davis Hospital	Yolo	Modified Base				X				X
Woodland Memorial Hospital	Yolo	Modified Base				X				X
Rideout Memorial Hospital	Yuba	Modified Base		X					X	

## S-SV EMS MCI CONTROL FACILITIES

Control Facility	County / Area of Responsibility
Enloe Medical Center	Butte and Colusa Counties
Rideout Memorial Hospital	Sutter and Yuba Counties
Sierra Nevada Memorial Hospital	Western Slope of Nevada County
Sutter Roseville Medical Center	Western Slope of Placer County
Tahoe Forest Hospital	Tahoe Basin and Eastern Slope of Nevada and Placer Counties
Woodland Memorial Hospital	Yolo County
UC Davis Medical Center	When requested by Woodland Memorial Hospital and agreed to by UCDCM, to handle patient dispersal for those MCI events that occur in Yolo County but patient dispersal will be primarily into Sacramento County
Mercy Medical Center Redding	Shasta County / Siskiyou County / Tehama County

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 506

## SUBJECT: CARDIOVASCULAR “STEMI” RECEIVING CENTERS

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### PURPOSE:

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

### AUTHORITY:

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

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

### DEFINITIONS:

- A. **STEMI** – ST Elevation Myocardial Infarction
- B. **PCI** – Percutaneous Coronary Intervention
- C. **Cardiovascular STEMI Receiving Centers (SRC)** – S-SV EMS designated facilities that have emergency interventional cardiac catheterization capabilities
- D. **STEMI Referring Centers** – Facilities that do not have emergency interventional cardiac catheterization capabilities

### POLICY:

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

- A. Licensure as a Cardiac Catheterization Laboratory.
- B. Intra-aortic balloon pump capability.
- C. Cardiovascular surgical services permit:  
*This requirement may be waived by the EMS Agency Medical Director when appropriate for patient or system needs. The Medical Director will evaluate conformance with existing American College of Cardiology / American Heart Association or other existing professional guidelines for standards.*
- D. Communication system for notification of incoming STEMI patients, available twenty four (24) hours per day, seven (7) days per week including a dedicated 12 Lead ECG receiving station and an in-house paging system.

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**Date last Reviewed / Revised: 11/11**

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**SUBJECT:   CARDIOVASCULAR “STEMI” RECEIVING CENTERS**

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- E. Provide CE opportunities, minimum of four (4) hours per year, for EMS personnel in areas of 12 Lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.
- F. Provide public education about STEMI warning signs and importance of early utilization the 9-1-1 system.

**G. STAFFING REQUIREMENTS**

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

**1. Medical Directors**

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

**2. Nursing Director**

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

**3. On-Call Physician Consultants and Staff**

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

- a. Cardiologist with percutaneous coronary intervention (PCI) privileges.
- b. Cardiovascular Surgeon, if cardiovascular surgical services are offered.  
*If cardiovascular surgical services are not available on site, the facility must have a rapid transfer agreement in place with a facility that provides this service. This agreement must be on file with the S-SV EMS Agency. This agreement must include the requirement that the cardiac surgical hospital cannot “refuse” transfer based on limitation of resources (e.g. lack of available beds, or staff to care for the patient) for true emergent patients. Additionally, the facility must have a rapid transport agreement with an S-SV EMS approved transport provider agency. The expectation will be that the patient will arrive at the cardiac surgical hospital within one (1) hour of the decision to operate, in emergency cases.*
- c. Cardiac Catheterization Laboratory team.
- d. Intra-aortic balloon pump capabilities 24/7.

**H. INTERNAL HOSPITAL POLICIES**

The hospital shall develop internal policies for the following situations:

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

**SUBJECT: CARDIOVASCULAR “STEMI” RECEIVING CENTERS**

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2. Diversion of STEMI patients **only** during times of an incapacitating internal disaster. A written notification describing such events must be submitted to S-SV EMS within twenty four (24) hours of occurrence.
3. Prompt acceptance of appropriate STEMI patients from other STEMI referral centers that do not have PCI capability.

**I. DATA COLLECTION / CONTINUOUS QUALITY IMPROVEMENT PROGRAM / PERFORMANCE STANDARDS**

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

**DESIGNATION**

- A. The Cardiovascular STEMI Receiving Center applicant shall be designated after satisfactory review of written documentation and an initial site survey by S-SV EMS or its designees and completion of a contract between the hospital and S-SV EMS.
- B. Initial designation as a SRC shall be for a period of four (4) years. Thereafter, re-designation shall occur every four (4) years, contingent upon satisfactory review.
- C. Failure to comply with the criteria and performance standards outlined in this policy and individual SRC facility contracts may result in probation, suspension or rescission of SRC designation. Compliance will be solely determined by the S-SV EMS Agency.

**PATIENT DESTINATION**

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

- A. An S-SV EMS designated SRC should be considered as the destination of choice if all of the following criteria are met:
  1. Identified STEMI patients based on machine interpretation of field 12 Lead ECG, verified by paramedics.
  2. Total transport time to the SRC is forty-five (45) minutes or less.
  3. Paramedics shall notify the SRC emergency department of the patient’s pending arrival by advising of a “STEMI ALERT” as soon as possible, to allow timely activation of the Cardiac Catheterization Lab team at the SRC.
- B. SRC destination will be in accordance with the guidelines used from the S-SV EMS Patient Destination Policy, Reference No. 505.
- C. Base / modified base hospital contact and consultation is mandatory in these and similar situations:

**SUBJECT:   CARDIOVASCULAR “STEMI” RECEIVING CENTERS**

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1. Patients in cardiac arrest, refractory ventricular fibrillation, or with an unmanageable airway should be considered for transport to the closest receiving hospital.
2. Patients with unstable ventricular tachycardia, ventricular fibrillation, second degree type II heart block and third degree heart blocks may be considered for transport to the closest receiving hospital, based on specific clinical scenario.
3. Patients with obvious contraindications to thrombolytic therapy should be considered for transport to the closest SRC.
4. In the rare instance when the closest SRC Cardiac Catheterization Laboratory is unavailable, the patient should be transported to the next closest SRC if the total transport time to the alternate SRC is forty-five (45) minutes or less.

**CROSS REFERENCES:**

Prehospital Care Policy Manual

12 Lead Program, Reference No. 440

Patient Destination, Reference No. 505

S-SV EMS Base / Receiving Hospital Capabilities, Reference No. 505-A

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

Chest Pain or Suspected Symptoms of Cardiac Origin, Reference No. C-8

**SIERRA-SACRAMENTO VALLEY EMS AGENCY**

**EQUIPMENT / SUPPLIES / VEHICLES  
SECTION VII**

**SUBJECT: INDEX**

**REFERENCE NO. 700**

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- 701** ALS Service Provider Inventory
- 702** Fireline Paramedic Inventory
- 703** LALS Service Provider Inventory
- 704** BLS Ambulance Service Provider Inventory
- 705** ALS / LALS Unit Inspection
- 706** Equipment and Supply Shortages
- 710** Management of Controlled Substances
- 715** Biomedical Equipment Maintenance

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 701

**SUBJECT: ALS INVENTORY**

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**PURPOSE:**

To establish a standardized inventory on all S-SV approved Advanced Life Support EMS response vehicles.

**AUTHORITY:**

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

California Code of Regulations, Title 22, Division 9, Section 100173

California Code of Regulations, Title 13

California Vehicle Code, Section 2418.5

Emergency Medical Services Authority Guidelines and Recommendations,  
Highway Patrol Handbook 82.4

**POLICY:**

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

**For inventory list see attached table**

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<b>Sierra-Sacramento Valley EMS Agency</b>			
<b>EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS</b>			
	MINIMUM QUANTITY REQUIRED		
	ALS Transport	ALS NON Transport	BIKES
<b>RADIO EQUIPMENT</b>			
Mobile UHF Med-Net Radio	1	1	0
Portable UHF Med-Net Radio <b>OR</b> Portable Cell Phone	1	1	1
<b>MISCELLANEOUS EQUIPMENT &amp; SUPPLIES</b>			
Map Book (covering the areas the ambulance provides service)	1 each	1 each	0
D.O.T Emergency Response Guidebook	1	1	0
FIRESCOPE Field Operations Guide (FOG)	1	1	0
Hazardous Materials medical management reference	1	1	0
Approved ePCR	1	1	1
RAS / AMA Forms	10 each	5 each	5 each
Triage Tags	10 each	10 each	0
Infection control packs (per crew member)	1 pk each	1 pk each	1 pk
Antiseptic hand wipes <b>or</b> waterless hand sanitizer	10 / 1	10 / 1	10 / 1
Covered waste container (red bio hazard bags acceptable)	1	1	0
Adult & Pediatric BP cuff	1 each	1 each	1 each
Thigh BP cuff	1	1	0
Stethoscope	1	1	1
Flashlight or Penlight	1	1	1
Bedpan or Fracture pan	1	0	0
Urinal	1	0	0
Sharps container	1	1	1
Padded soft wrist & ankle restraints	1 set	1 set	0
Pillows, sheets, pillow cases, towels	2 each	0	0
Blankets	2	2	0
Emesis basin / disposable emesis bags	2	2	0
Length based Pediatric Resuscitation Tape (Broselow)	1	1	1
Ambulance cot with straps to secure patient to cot and necessary equipment to properly secure cot in vehicle	1	0	0
Collapsible stretcher (Breakaway Flat) with straps to secure patient	1	0	0
Thermometer (optional)	1	1	0
<b>BIOMEDICAL EQUIPMENT &amp; SUPPLIES</b>			
<b>Monitor / Defibrillator Equipment &amp; Supplies</b>			
Portable Monitor/Defibrillator - Battery operated, with ECG printout, capable of synchronized cardioversion. (Transcutaneous Pacing, Waveform Capnography, &/or 12 Lead capability optional).	1	1	0
AED with cardiac monitoring and manual defibrillation capabilities (optional in place of portable monitor / defibrillator above for bike teams only)	0	0	1
Spare monitor/ defibrillator battery	1	1	as needed
Defibrillator paddles - adult & pediatric with defibrillation gel pads or paddle conduction gel <b>OR</b> Hands free defibrillator patches - adult & pediatric	1 set each	1 set each	1 set each
Electrode leads (wires)	2 sets	2 sets	1 set
ECG paper	2 rolls	2 rolls	as needed
Adult disposable ECG electrodes	4 sets	2 sets	2 sets
Pediatric disposable ECG electrodes	2 sets	1 set	2 sets
<b>Miscellaneous Biomedical Equipment &amp; Supplies</b>			
Pulse Oximeter	1	1	1
Capnometer (optional)	1	1	1
Co-Oximeter (optional)	1	1	1
Glucometer	1	1	1
Glucometer test strips	10	10	5
Lancets	10	10	5
<b>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES</b>			
<b>Oxygen Delivery</b>			
"H" or "M" oxygen tank mounted in ambulance	1	0	0
Wall mounted oxygen regulator with liter flow mounted in ambulance	1	0	0

## Sierra-Sacramento Valley EMS Agency EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS

	MINIMUM QUANTITY REQUIRED		
	ALS Transport	ALS NON Transport	BIKES
<b>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES (cont.)</b>			
"D" or "E" portable oxygen cylinder ("C" size acceptable for bike teams)	2	1	1
Portable oxygen regulator with liter flow	1	1	1
Adult non-rebreather oxygen mask	6	2	1
Pediatric oxygen mask	2	2	1
Nasal cannula	6	2	1
Hand held nebulizer	2	1	1
Aerosol / nebulizer mask	2	1	0
<b>Bag-Valve Device</b> (with O2 inlet, reservoir & one way valve)			
Adult (1000 cc bag vol.)	1	1	1
Pediatric (450 - 500 cc bag vol.)	1	1	0
<b>Bag-Valve Mask</b> (transparent)			
Large (adult)	1	1	1
Medium (adult)	1	1	0
Small (adult)	1	1	0
Child	1	1	1
Neonatal	1	1	1
<b>BLS Airways</b>			
Oropharyngeal Airways (sizes 0-6 or equivalent sizes)	2 each	2 each	1 each
Nasopharyngeal Airways (sizes 24-34 Fr. or equivalent sizes)	2 each	2 each	1 each
<b>Suction Equipment &amp; Supplies</b>			
Suction catheters - 6 fr, 8 fr, 10 fr, 14 fr	2 each	2 each	0
Tonsillar tip suction handle	2	2	0
Portable mechanical suction unit (manual suction device including adult & pediatric suction tubes acceptable for bike teams)	1	1	1
<b>Advanced Airway Equipment &amp; Supplies</b>			
Laryngoscope handle	1	1	1
Batteries - extra set	2	2	1
Bulb - extra bulb for adult and pediatric blade	1 each	1 each	1 each
Miller (straight blade) sizes 0-4	1 each	1 each	1 each
Macintosh (curved blade) sizes 3-4	1 each	1 each	1 each
Magill forceps - adult & pediatric	1 each	1 each	1 each
Water soluble lubricant (K-Y jelly or equivalent)	4	1	1
Topical vasoconstrictor (Neosynephrine or equivalent)	1	1	1
2% Lidocaine jelly	1 tube	1 tube	1 tube
Cuffed endotracheal tubes, sizes 2.5, 3.0	2 each	2 each	1 each
Cuffed endotracheal tubes, sizes 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5	2 each	2 each	1 each
Cuffed endotracheal tube, size 9.0	2 each	2 each	0
Endotracheal tube stylettes - neonatal, child & adult	1 each	1 each	1 each
Flex Guide ETT introducer - caudal tip 15 fr x 70 cm	2	2	1
ET tube holder	2	2	1
Esophageal Tracheal Airway Device - Adult 37 and 41 Fr <b>OR</b> King Airway Device - Size 3, Size 4, Size 5	1 each	1 each	0
End tidal CO2 detector device - disposable single patient use colorimetric device (adult & pediatric) or disposable capnography circuit	2 each	2 each	1 each
Esophageal Intubation Detector Device (EDD) (optional for providers using waveform capnography)	2	1	1
Meconium aspirator	1	1	0
Airway airflow monitor (optional)	2	2	0
Inspiratory Impedance Threshold Device (optional)	2	2	0
S-SV approved CPAP equipment	2	1	0
Manual Jet Ventilator device <b>OR</b> ENK Flow Modulator Kit	1	1	1
Adult and Pediatric Transtracheal Catheter or minimum 12 ga x 3" catheter for use with the manual Jet Ventilator device (if carried)	1 each	1 each	1 each

<b>Sierra-Sacramento Valley EMS Agency EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS</b>			
	MINIMUM QUANTITY REQUIRED		
	ALS Transport	ALS NON Transport	BIKES
<b>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES (cont.)</b>			
Needle thoracostomy kit with minimum 14 ga X 3 " catheter specifically designed for needle decompression	1	1	1
<b>IMMOBILIZATION EQUIPMENT &amp; SUPPLIES</b>			
Ked	1	1	0
Long spine board with straps	2	2	0
Pediatric spine board	1	1	0
Foam-filled or equivalent S-SV approved head immobilization device	2 pair	2 pair	0
Traction splint: Hare, Sager or equivalent	1	1	0
Arm & leg splints (i.e. cardboard, SAM type, vacuum)	3 each	3 each	0
Tape (optional) *Type approved by SSV EMSA Medical Director	1 roll	1 roll	0
Cervical Collars (rigid) - large, medium, small, pediatric <u>OR</u> adjustable adult & pediatric	2 each	2 each	0
<b>OBSTETRICAL EQUIPMENT &amp; SUPPLIES</b>			
OB Kit containing a minimum: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe and clean plastic bags.	2 kits	1 kit	1 kit
Stocking head cap (infant)	2	2	0
<b>BANDAGING EQUIPMENT &amp; SUPPLIES</b>			
Triangle bandages	4	4	4
Adhesive tape rolls 1" & 2" rolls	2 each	2 each	1 each
Sterile 4x4 compresses	12	12	4
Non sterile 4x4 compresses	50	50	10
Kling/Kerlix in 2", 3" or 4" rolls	10	6	4
Trauma dressing (10"x30" or larger universal dressings)	4	2	1
Surgipads (optional)	6	6	2
Band-Aids	1 box	1 box	10
Sterile petroleum impregnated dressing	4	4	2
Asherman Chest Seal (optional)	1	1	1
Cold packs and heat packs	2 each	2 each	2 each
Gloves (unsterile) various sizes	1 box each	10 each	2 pr each
Sterile saline for irrigation	2 liters	2 liters	0
Potable water	2 liters	2 liters	0
Bandage shears	1 pr	1 pr	1 pr
S-SV EMS Agency approved commercial tourniquet device (optional)	1	1	1
<b>IV / MEDICATION ADMINISTRATION EQUIPMENT &amp; SUPPLIES</b>			
Catheter over needle- 14 ga, 16 ga, 18 ga, 20 ga	6 each	4 each	2 each
Catheter over needle- 22ga, 24ga	2 each	2 each	2 each
Micro-drip & Macro-drip venosets <u>OR</u> Selectable drip tubing	4 each	2 each	1 each
Blood administration tubing (optional)	6	4	2
IV extension	2	2	0
IV extension	4	2	1
Saline Locks (optional)	2	2	1
IV start pack or equivalent with tourniquets	4	4	2
Alcohol wipes & Betadine swabs	20 each	10 each	8 each
Chlorhexidine swabs/skin prep	5 each	5 each	2 each
<b>Syringes / Needles / Medication Administration Devices</b>			
TB / 1 cc syringe	3	2	2
3 - 5 cc syringe	3	2	2
10 - 12 cc syringe	3	2	2
20 cc syringe	1	1	1
50 - 60 cc syringe	1	0	0
22 ga, 25 ga safety injection needles	2 each	2 each	2 each
Vial access Cannulas	2 each	2 each	2 each
Mucosal Atomization Device (MAD)	4	2	0
Arm boards - (short, long)	2 each	1 each	0

## Sierra-Sacramento Valley EMS Agency EQUIPMENT AND SUPPLY SPECIFICATIONS - ALS

	MINIMUM QUANTITY REQUIRED		
	ALS Transport	ALS NON Transport	BIKES
<b>IV / MEDICATION ADMINISTRATION EQUIPMENT &amp; SUPPLIES (cont.)</b>			
Blood Tubes (optional)	4	2	0
Vacutainer holder (optional)	1	1	0
Vacutainer needles (optional)	4	4	0
Vials or pre-filled syringes - Sterile Normal Saline for injection (optional)	2	2	1
<b>INTRAOSSUEOUS ACCESS EQUIPMENT &amp; SUPPLIES</b>			
ALS providers must stock the equipment and supplies to establish IO access on both an adult and pediatric patient as indicated below:			
<b>Pediatric IO Devices (providers must stock one of the following devices in the minimum quantity listed)</b>			
Jamshidi ® Illinois device with 15 ga adjustable length needle	2	1	1
Bone Injection Gun (B.I.G. ®) - Pediatric	2	1	1
EZ-IO ® 15 mm Pediatric Needle Set (including a minimum of 1 EZ-IO ® Power Driver used for both adult and pediatric patients)			
<b>Adult IO Devices (providers must stock one of the following devices in the minimum quantity listed)</b>			
Bone Injection Gun (B.I.G. ®) - Adult	2	1	1
EZ-IO ® Adult Needle Set (including a minimum of 1 EZ-IO ® Power Driver used for both adult and pediatric patients). At least one needle set shall be 45 mm length	2	1	1
Lidocaine HCl 2% (100mg/5ml)	1	1	1
<b>IV SOLUTIONS</b>			
Normal saline - 1000 cc bag	8	3	2
Normal saline - 250 cc bag	2	1	0
<b>MEDICATIONS</b>			
Activated charcoal (50 gm)	1	1	0
Adenosine 6 mg - vial or pre-filled syringe	5	5	5
Albuterol - 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5cc, without preservatives, is required for dilution of each dose.	3	2	2
Amiodarone 3 ml - 150 mg (50 mg/ml)	6	6	6
Aspirin (chewable)	1 bottle	1 bottle	1 bottle
Atropine 1 mg/1ml vial	6	6	4
Benadryl (50 mg/ml)	2	2	2
Benadryl elixir - 100 mg	1	1	1
Calcium Chloride 10% - (1 gm/10ml)	4	2	1
Dextrose 50% (25gm/50ml)	2	2	1
Dextrose 25% (12.5gm/10ml)	2	1	0
Dopamine 400 mg	1	1	0
Epinephrine 1:1,000	5 mg	5 mg	5 mg
Epinephrine 1:10,000 (1mg/10ml)	8	4	4
Furosemide 40 mg (10mg/ml)	2	2	2
Glucagon 1mg (1unit)	1	1	1
Glucose paste <b>OR</b> Glucose solution (oral prepackaged)	2	2	1
Mark-I / Duo Dote Nerve Agent Antidote Kits (optional)	(Optional)	(Optional)	(Optional)
Naloxone (Narcan) 2.0 mg	4	4	2
Nitroglycerin 0.4 mg/tab (1/150) bottle <b>OR</b> Nitroglycerine spray actuation	2	1	1
Pralidoxime Chloride (2-PAM) 1 gm / 20 ml vial (optional)	(Optional)	(Optional)	(Optional)
Sodium Bicarbonate (50mEq/50ml)	2	1	1
Zofran (4mg/2ml vial)	4	2	2
Zofran Oral Disintegrating Tablets (ODT) 4 mg	4	2	2
<b>Controlled Substances</b>			
Midazolam (Versed) 5 mg/cc concentration	20 - 60 mg	20 - 60 mg	20 mg (Optional)
Morphine HCL 10 mg/ml unit dose	20-60 mg	20-60 mg	20 mg (Optional)
Double lock container system for controlled meds.	1	1	1
Controlled substance log sheet	1	1	1

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 702

**SUBJECT: FIRELINE PARAMEDIC INVENTORY**

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**PURPOSE:**

To establish a standardized inventory for S-SV approved Advanced Life Support (ALS) Provider accredited paramedics, when requested through the statewide Fire and Rescue Mutual Aid System, to respond to and provide ALS care on the fireline at Wildland fires.

**AUTHORITY:**

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

California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167

**POLICY:**

California Code of Regulations Title 22, Division 9, Section 100165 (l) states:

*“During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting local EMS agency.”*

All S-SV approved ALS provider accredited paramedics responding to Wildland fires to provide ALS care on the fireline shall carry the following ALS inventory in their pack while on the fireline. Reasonable variations may occur, however, any exceptions or additions shall have prior approval of the S-SV EMS Agency.

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**Effective Date: 06/01/2012**  
**Next Review Date: 06/2015**  
**Approved:**

**Date last Reviewed / Revised: 06/12**  
**Page 1 of 4**

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**S-SV EMS Regional Executive Director**

**SUBJECT: FIRELINE PARAMEDIC INVENTORY**

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**FIRELINE PARAMEDIC  
(ALS) PACK INVENTORY****ALS AIRWAY EQUIPMENT:**

- Laryngoscope handle
- Extra batteries and bulb (1 ea)
- Miller /McIntosh-adult sizes  
(Light-weight disposable  
Recommended)
- Water soluble lubricant (1)
- ET tubes cuffed 6.5-8.5 (1 ea)
- Stylette (adult)
- ET tube holder
- Capnostat Sensor
- Rescue Airway
- Needle Thoracostomy Kit (1)
- Esophageal intubation  
detector device
- 2% Lidocaine jelly (1 tube)
- Topical vasoconstrictor (1)

**IV / MEDICATION ADMIN  
SUPPLIES:**

- Saline 0.9% IV 1000 ML (1)
- IV Administration Set-  
Macro-Drip (2)
- Venaguard (2)
- Alcohol Preps (6)
- Betadine Swabs (4)
- IV start pack with Tourniquet  
(2)
- Razor (1)
- Adhesive Tape (1)
- IV Catheters (2 ea)  
14, 16, 18, 20 ga,
- 10 cc Syringe (2)

- TB Syringe (2)
- 18 ga. Needle (4)
- 25 ga. Needle (2)
- FDA approved drill type device for  
adult IO access (1 optional)

**MISCELLANEOUS:**

- Sharps Shuttle (1)
- Double Lock Container System (1)
- Controlled Substance Log Sheet (1)
- Controlled Substance Seals (4)
- FEMT-P Pack Inventory Sheet (1)
- Cellular Phone & D/C Charger (1)
- PCR (6)
- AMA Forms (3)
- Antiseptic hand wipes (10)
- Red Bio-Hazard Bags (2)

**BIOMEDICAL EQUIPMENT:**

- Monitor defibrillator or Compact  
Semi-Auto AED with screen (1)
- Monitor/AED defibrillator patches  
adult (2)
- Monitor/AED Spare Batteries (1)
- Monitor/AED electrode wires (1 set)
- EKG Paper (1 spare roll)
- Adult disposable EKG electrodes (2  
sets)
- Pulse Oximeter (1 Optional)
- Glucometer (1)
- Glucometer test strips (5)
- Spare glucometer lancets (5)

**SUBJECT: FIRELINE PARAMEDIC INVENTORY**

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**MEDICATIONS:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Aerosolized Beta 2 Specific Bronchodilator with spacer (4)</li> <li><input type="checkbox"/> Amiodarone 150 mg (3)</li> <li><input type="checkbox"/> Aspirin-Chewable 80 mg (1 bottle)</li> <li><input type="checkbox"/> Atropine Sulfate 1 mg/1ml vial (2)</li> <li><input type="checkbox"/> Dextrose 50% (25gm/50ml) Pre-Load (1)</li> <li><input type="checkbox"/> Diphenhydramine 50 mg Vials (2)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Diphenhydramine Elixer 100 mg (1)</li> <li><input type="checkbox"/> Epinephrine 1:10,000 Pre-Load Syringes 1 mg/10ml (2)</li> <li><input type="checkbox"/> Epinephrine 1:1000 1 mg/1ml Ampules (4)</li> <li><input type="checkbox"/> Glucagon 1mg/unit (1)</li> <li><input type="checkbox"/> Glucose Paste (1)</li> <li><input type="checkbox"/> Midazolam-Versed 5 mg/1ml (4)</li> <li><input type="checkbox"/> Morphine Sulfate 10 mg/ml (6)</li> <li><input type="checkbox"/> Naloxone-Narcan 2 mg (2)</li> <li><input type="checkbox"/> Nitro Spray 1/150 (1)</li> </ul> |
|--|--|

Additional items for re-stock should also be maintained and secured in vehicle or in the Medical Unit trailer.

NOTE: Providers should stock sufficient quantities of medical supplies and medications- especially controlled substance medications, to avoid mid-incident restock. Incident Medical Units may not be capable of re-supplying controlled substances (Narcotics). Narcotics should be secured as per S-SV EMS Agency policy and the Fireline Paramedic providers SOP.

In addition to the required ALS equipment listed above, the following BLS items, or equivalents, shall also be available on the fireline. The Fireline Paramedic should report to the incident with the full compliment of EMS supplies ready to work. The incident will re-supply the Fireline Paramedic to the best of its ability.

**BASIC LIFE SUPPORT (BLS)  
PACK INVENTORY**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Airway, Oral Pharyngeal Kit (1)</li> <li><input type="checkbox"/> Biohazard Bag (2)</li> <li><input type="checkbox"/> Bag Valve Mask (1)</li> <li><input type="checkbox"/> BVM Mask lg adult (1)</li> <li><input type="checkbox"/> Space Blanket (1)</li> <li><input type="checkbox"/> Bandage, Sterile 4x4, Compress (6)</li> <li><input type="checkbox"/> Bandage, Triangular, (2)</li> <li><input type="checkbox"/> Cervical Collar, Adjustable (1)</li> <li><input type="checkbox"/> Cold Pack (3)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Dextrose Oral (1)</li> <li><input type="checkbox"/> Dressing, Trauma, 10x30 (4)</li> <li><input type="checkbox"/> Eye Wash (1 bt)</li> <li><input type="checkbox"/> Pen Light or flashlight (1)</li> <li><input type="checkbox"/> Gloves, Latex (L, M, S) (2 pr)</li> <li><input type="checkbox"/> Coban Wraps/Ace bandage (2 ea)</li> <li><input type="checkbox"/> Kerlix, Kling, 4.5, Sterile (4)</li> <li><input type="checkbox"/> Mask, Face, Disposable w/eye shield (1)</li> <li><input type="checkbox"/> Pad, Writing (1)</li> </ul> |
|---|---|

**SUBJECT: FIRELINE PARAMEDIC INVENTORY**

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- Pen
- Pencil (wet environments)
- Pin, Safety (in triangular dressing kit)
- Splinter Kit (1)
- Scissors, Medic (1)
- Sheet, Burn (2)
- Stethoscope (1)
- Sphygmomanometer (1)
- Splint, Moldable
- Suction, Manual, V-Vac (1)
- Tape, 1 Inch, Cloth (2 rolls)
- Petroleum Dressing (2)
- Thermometer, Digital (1)
- Triage Tags with ties waterproof (6)
- PCRs (Incident PCR for BLS)

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 703

## SUBJECT: LIMITED ADVANCED LIFE SUPPORT (LALS) INVENTORY

### **PURPOSE:**

To establish a standardized inventory on all S-SV approved Limited Advanced Life Support (LALS) EMS response vehicles.

### **AUTHORITY:**

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

California Code of Regulations, Title 22, Division 9, Chapter 3

California Code of Regulations, Title 13

California Vehicle Code, Section 2418.5

Emergency Medical Services Authority Guidelines and Recommendations,  
Highway Patrol Handbook 82.4

### **POLICY:**

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

**For inventory list see attached table**

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**Effective Date: 06/01/2012**  
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**Approved:**

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**Page 1 of 1**

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<b>Sierra-Sacramento Valley EMS Agency</b>		
<b>EQUIPMENT AND SUPPLY SPECIFICATIONS - LALS</b>		
	MINIMUM QUANTITY REQUIRED	
	LALS TRANSPORT	LALS NON TRANSPORT
<b>RADIO EQUIPMENT</b>		
Mobile UHF Med-Net Radio	1	1
Portable UHF Med-Net Radio <u>OR</u> Portable Cell Phone	1	1
<b>MISCELLANEOUS EQUIPMENT &amp; SUPPLIES</b>		
Map Book (covering the areas the ambulance provides service)	1 each	1 each
D.O.T Emergency Response Guidebook	1	1
FIRESCOPE Field Operations Guide (FOG)	1	1
Hazardous Materials medical management reference	1	1
Approved ePCR	1	1
RAS / AMA forms	10 each	5 each
Triage Tags	10 each	10 each
Infection control packs (per crew member)	1 pk each	1 pk each
Antiseptic hand wipes <u>or</u> waterless hand sanitizer	10 / 1	10 / 1
Covered waste container (red bio hazard bags acceptable)	1	1
Adult & Pediatric BP cuff	1 each	1 each
Thigh BP cuff	1	1
Stethoscope	1	1
Flashlight or Penlight	1	1
Bedpan or Fracture pan	1	0
Urinal	1	0
Sharps container	1	1
Padded soft wrist & ankle restraints	1 set	1 set
Pillows, sheets, pillow cases, towels	2 each	0
Blankets	2	2
Emesis basin / disposable emesis bags	2	2
Length based Pediatric Resuscitation Tape (Broselow)	1	1
Ambulance cot with straps to secure patient to cot and necessary equipment to properly secure cot in vehicle	1	0
Collapsible stretcher (Breakaway Flat) with straps to secure patient	1	0
Thermometer (optional)	1	1
<b>BIOMEDICAL EQUIPMENT &amp; SUPPLIES</b>		
<b>Monitor / Defibrillator Equipment &amp; Supplies</b>		
Portable Monitor/Defibrillator - Battery operated, with ECG printout, capable of synchronized cardioversion.	1	1
Spare monitor/ defibrillator battery	1	1
Defibrillator paddles - adult & pediatric with defibrillation gel pads or paddle conduction gel <u>OR</u> Hands free defibrillator patches - adult & pediatric	1 set each	1 set each
Electrode leads (wires)	2 sets	2 sets
ECG paper	2 rolls	2 rolls
Adult disposable ECG electrodes	4 sets	2 sets
Pediatric disposable ECG electrodes	2 sets	1 set
<b>Miscellaneous Biomedical Equipment &amp; Supplies</b>		
Pulse Oximeter	1	1
Glucometer	1	1
Glucometer test strips	10	10
Lancets	10	10
<b>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES</b>		
<b>Oxygen Delivery</b>		
"H" or "M" oxygen tank mounted in ambulance	1	0
Wall mounted oxygen regulator with liter flow mounted in ambulance	1	0
"D" or "E" portable oxygen cylinder ("C" size acceptable for bike teams)	2	1
Portable oxygen regulator with liter flow	1	1
Adult non-rebreather oxygen mask	6	2
Pediatric oxygen mask	2	2
Nasal cannula	6	2

<b>Sierra-Sacramento Valley EMS Agency</b>		
<b>EQUIPMENT AND SUPPLY SPECIFICATIONS - LALS</b>		
	<b>MINIMUM QUANTITY REQUIRED</b>	
	<b>LALS TRANSPORT</b>	<b>LALS NON TRANSPORT</b>
<b>AIRWAY / OXYGEN EQUIPMENT &amp; SUPPLIES (cont.)</b>		
Hand held nebulizer	2	1
Aerosol / nebulizer mask	2	1
<b>Bag-Valve Device</b> (with O2 inlet, reservoir & one way valve)		
Adult (1000 cc bag vol.)	1	1
Pediatric (450 - 500 cc bag vol.)	1	1
<b>Bag-Valve Mask</b> (transparent)		
Large (adult)	1	1
Medium (adult)	1	1
Small (adult)	1	1
Child	1	1
Neonatal	1	1
<b>BLS Airways</b>		
Oropharyngeal Airways (sizes 0-6 or equivalent sizes)	2 each	2 each
Nasopharyngeal Airways (sizes 24-34 Fr. or equivalent sizes)	2 each	2 each
Water soluble lubricant (K-Y jelly or equivalent)	4	1
<b>Suction Equipment &amp; Supplies</b>		
Suction catheters - 6 fr, 8 fr, 10 fr, 14 fr	2 each	2 each
Tonsillar tip suction handle	2	2
Portable mechanical suction unit (manual suction device including adult & pediatric suction tubes acceptable for bike teams)	1	1
<b>Advanced Airway Equipment &amp; Supplies</b>		
Advanced Airway tube holder	2	2
Esophageal Tracheal Airway Device - Adult 37 and 41 Fr <b>OR</b> King Airway Device - Size 3, Size 4, Size 5	1 each	1 each
End tidal CO2 detector device - disposable single patient use colorimetric device (adult) or disposable capnography circuit	2 each	2 each
Esophageal Intubation Detector Device (EDD)	2	1
S-SV approved CPAP equipment (optional)	2	1
<b>IMMOBILIZATION EQUIPMENT &amp; SUPPLIES</b>		
Ked	1	1
Long spine board with straps	2	2
Pediatric spine board	1	1
Foam-filled or equivalent S-SV approved head immobilization device	2 pair	2 pair
Traction splint: Hare, Sager or equivalent	1	1
Arm & leg splints (i.e. cardboard, SAM type, vacuum)	3 each	3 each
Tape (optional) *Type approved by SSV EMSA Medical Director	1 roll	1 roll
Cervical Collars (rigid) - large, medium, small, pediatric <b>OR</b> adjustable adult & pediatric	2 each	2 each
<b>OBSTETRICAL EQUIPMENT &amp; SUPPLIES</b>		
OB Kit containing: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe, clean plastic bags and stocking head cap.	2 kits	1 kit
<b>BANDAGING EQUIPMENT &amp; SUPPLIES</b>		
Triangle bandages	4	4
Adhesive tape rolls 1" & 2" rolls	2 each	2 each
Sterile 4x4 compresses	12	12
Non sterile 4x4 compresses	50	50
Kling/Kerlix in 2", 3" or 4" rolls	10	6
Trauma dressing (10"x30" or larger universal dressings)	4	2
Surgipads (optional)	6	6
Band-Aids	1 box	1 box
Sterile petroleum impregnated dressing	4	4
Asherman Chest Seal (optional)	2	1
Cold packs and heat packs	2 each	2 each
Gloves (unsterile) various sizes	1 box each	10 each

<b>Sierra-Sacramento Valley EMS Agency</b>		
<b>EQUIPMENT AND SUPPLY SPECIFICATIONS - LALS</b>		
	<b>MINIMUM QUANTITY REQUIRED</b>	
	<b>LALS TRANSPORT</b>	<b>LALS NON TRANSPORT</b>
<b>BANDAGING EQUIPMENT &amp; SUPPLIES (cont.)</b>		
Sterile saline for irrigation	2 liters	2 liters
Potable water	2 liters	2 liters
Bandage shears	1 pr	1 pr
S-SV EMS Agency approved commercial tourniquet device (optional)	1	1
<b>IV / MEDICATION ADMINISTRATION EQUIPMENT &amp; SUPPLIES</b>		
Catheter over needle- 14ga, 16ga, 18ga, 20 ga	6 each	4 each
Catheter over needle- 22ga, 24ga	2 each	2 each
Micro-drip & Macro-drip venosets <b>OR</b>	4 each	2 each
Selectable drip tubing	6	4
Blood administration tubing (optional)	2	2
IV extension	4	2
Saline Locks (optional)	2	2
IV start pack or equivalent with tourniquets	4	4
Alcohol wipes & Betadine swabs	20 each	10 each
Chlorhexidine swabs/skin prep	5 each	5 each
<b>Syringes / Needles / Medication Administration Devices</b>		
TB / 1 cc syringe	3	2
3 - 5 cc syringe	3	2
10 - 12 cc syringe	3	2
20 cc syringe	1	1
50 - 60 cc syringe	1	0
22ga, 25 ga safety injection needles	2 each	2 each
Vial Access Cannulas	2 each	2 each
Mucosal Atomization Device (MAD)	4	2
<b>Miscellaneous IV / Medication Administration Equipment &amp; Supplies</b>		
Arm boards - (short, long)	2 each	1 each
Blood Tubes / Vacutainer holder / needles (optional)	(Optional)	(Optional)
Vials or pre-filled syringes - Sterile Normal Saline for injection (optional)	2	2
<b>IV SOLUTIONS</b>		
Normal saline - 1000 cc bag	8	3
Normal saline - 250 cc bag	2	1
<b>MEDICATIONS</b>		
Activated charcoal (50 gm)	1	1
Albuterol - 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5cc, without preservatives, is required for dilution of each dose.	3	2
Aspirin (chewable)	1 bottle	1 bottle
Atropine 1 mg/1ml vial	6	6
Dextrose 50% (25gm/50ml)	2	2
Dextrose 25% (12.5gm/10ml)	2	1
Epinephrine 1:1,000	5 mg	5 mg
Epinephrine 1:10,000 (1mg/10ml)	8	4
Furosemide 40 mg (10mg/ml)	2	2
Glucagon 1mg (1unit)	1	1
Glucose paste <b>OR</b> Glucose solution (oral prepackaged)	2	2
Lidocaine 100 mg	6	3
Naloxone (Narcan) 2.0 mg	4	4
Nitroglycerin 0.4 mg/tab (1/150) bottle <b>OR</b> Nitroglycerine spray actuation	2	1
Sodium Bicarbonate (50mEq/50ml)	2	1
<b>Controlled Substances</b>		
Midazolam (Versed) 5 mg/cc concentration	20 - 60 mg	20 - 60 mg
Morphine HCL 10 mg/ml unit dose	20-60 mg	20-60 mg
Double lock container system for controlled meds.	1	1
Controlled substance log sheet	1	1

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 706

## **SUBJECT: EQUIPMENT AND SUPPLY SHORTAGES**

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### **PURPOSE**

To provide direction to prehospital provider agencies in the S-SV EMS Region on the appropriate notifications and procedures for an acute equipment or supply shortage or when it is anticipated that an equipment or supply shortage is likely to occur.

### **AUTHORITY**

California Health and Safety Code, Division 2.5

California Code of Regulations, Title 22, Division 9

### **POLICY**

This policy applies only to instances when an equipment or supply shortage is the result of a manufacturers recall, manufacturers back order, or is otherwise confirmed to be unavailable from routine EMS supply vendor sources. EMS prehospital provider agencies in the S-SV EMS Region are encouraged to maintain relationships with multiple vendor sources when possible in order to prevent or minimize disruption to the delivery of prehospital care in the S-SV EMS Region.

Prehospital provider agencies shall attempt to procure items for any reasonably available vendor source prior to notifying the S-SV EMS Agency and requesting assistance or direction. However, this notification shall be made timely enough to allow for appropriate action and direction by the S-SV EMS Agency prior to impacting prehospital patient care.

### **PROCEDURE**

- A. If a prehospital provider agency becomes aware of a potential supply or equipment shortage beyond their control, they shall first attempt to mitigate the situation utilizing the following means:
1. Attempt to procure the identified equipment or supplies from reasonably available alternate vendor sources.
  2. Complete a full inventory of the identified equipment or supplies (including restock supplies, back up vehicles and any other storage location) and rotate available stock to in service vehicles.

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**Effective Date: 06/01/2012**  
**Next Review Date: 01/2015**  
**Approved:**

**Date last Reviewed / Revised: 01/12**  
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**S-SV EMS Medical Director**

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**S-SV EMS Regional Executive Director**

**SUBJECT: EQUIPMENT AND SUPPLY SHORTAGES**

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- B. In the event of an acute equipment or supply shortage (i.e. manufacturer recall), the provider agency shall immediately notify the S-SV EMS Agency for appropriate direction.
- C. Once the S-SV EMS Agency is notified by a prehospital provider agency of an actual or potential equipment or supply shortage, any of the following actions may be implemented:
  - 1. Assist the prehospital provider agency in identifying other sources to procure the identified equipment or supplies.
  - 2. Approve a temporary policy variance allowing the prehospital provider agency to utilize the identified equipment or supplies in an alternate method, preparation, or concentration.
  - 3. Approve a temporary policy variance allowing the prehospital provider agency to stock less than the minimum required inventory of the identified equipment or supplies.
  - 4. Approve a temporary policy variance allowing the prehospital provider agency to utilize appropriate substitute equipment or supplies.
  - 5. Other direction determined by the S-SV EMS Medical Director.
- D. Any policy variance requested from and approved by the S-SV EMS Agency will only be on a temporary basis and will only apply to the identified equipment or supplies. Prehospital provider agencies shall continually attempt to procure the identified equipment or supplies and shall keep the S-SV EMS Agency updated as to the status of this procurement on a regular basis and/or as requested.
- E. When notified of an acute or potential equipment or supply shortage that has the potential to affect multiple prehospital provider agencies in the S-SV EMS Region, the S-SV EMS Agency will notify appropriate providers as soon as possible and will provide any necessary direction.

# SIERRA-SACRAMENTO VALLEY EMS AGENCY

## FIELD POLICIES & TREATMENT PROTOCOLS SECTION VIII

### **SUBJECT: INDEX**

### **REFERENCE NO. 800**

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- 801** EMT Scope of Practice
- 802** Advanced EMT Scope of Practice
- 803** Paramedic Scope of Practice
- 804** Emergency Medical Responder (EMR) Scope of Practice
- 812** Base / Modified Base / Receiving Hospital Contact
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# SIERRA-SACRAMENTO VALLEY EMS AGENCY

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- N-1 Altered Level of Consciousness

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**P-3** Apparent Life Threatening Event (ALTE)

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- P-6** Bradycardia – With Pulses
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- P-10** Foreign-Body Airway Obstruction
- P-12** Respiratory Failure / Arrest
- P-14** Respiratory Distress – Wheezing
- P-16** Respiratory Distress – Stridor
- P-18** Allergic Reaction / Anaphylaxis
- P-20** Shock
- P-22** Overdose &/or Poisoning
- P-24** Altered Level of Consciousness
- P-26** Seizure
- P-28** Burns Thermal & Electrical
- P-30** Isolated Extremity Injury – Including Hip and Shoulder Injuries
- P-32** Nausea / Vomiting (From Any Cause)
- P-34** Uncontrolled Extremity Bleeding

**Adult Patient Treatment Protocols (LALS)**

**Cardiovascular (LALS)**

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

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**Respiratory (LALS)**

- R-1** Airway Obstruction
- R-2** Respiratory Arrest
- R-3** Acute Respiratory Distress

**Medical (LALS)**

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

**Neurological (LALS)**

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

**Obstetrics / Gynecology (LALS)**

- OB/G-1** Childbirth

**Environmental (LALS)**

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

**SIERRA-SACRAMENTO VALLEY EMS AGENCY**

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**Trauma (LALS)**

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

**Pediatric Patient Treatment Protocols (LALS)**

- P-1** General Pediatric Protocol
- P-2** Neonatal Resuscitation
- P-3** Apparent Life Threatening Event (ALTE)
- P-4** Pulseless Arrest
- P-6** Bradycardia – With Pulses
- P-8** Tachycardia – With Pulses
- P-10** Foreign-Body Airway Obstruction
- P-12** Respiratory Failure / Arrest
- P-14** Respiratory Distress – Wheezing
- P-16** Respiratory Distress – Stridor
- P-18** Allergic Reaction / Anaphylaxis
- P-20** Shock
- P-22** Overdose and / or Poisoning
- P-24** Altered Level of Consciousness
- P-26** Seizure
- P-28** Burns Thermal & Electrical

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**P-30** Isolated Extremity Injury – Including Hip and Shoulder Injuries

**P-34** Uncontrolled Extremity Bleeding

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 801

## SUBJECT: EMT SCOPE OF PRACTICE

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### **PURPOSE:**

To define the EMT scope of practice in the S-SV EMS region.

### **AUTHORITY:**

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

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

### **POLICY:**

- A. During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:
1. Evaluate the ill and injured
  2. Render basic life support, rescue and emergency medical care to patients.
  3. Obtain diagnostic signs to include, but not be limited to, the assessment of temperature, blood pressure, pulse and respiration rates, level of consciousness, and pupil status.
  4. Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
  5. Use the following adjunctive airway breathing aids:
    - a. oropharyngeal airway;
    - b. nasopharyngeal airway;
    - c. suction devices;
    - d. basic oxygen delivery devices; and
    - e. manual and mechanical ventilating devices designed for prehospital use.
  6. Use various types of stretchers and body immobilization devices.

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**Effective Date: 06/01/2012**  
**Next Review Date: 06/2013**  
**Approved:**

**Date last Reviewed / Revised: 06/12**  
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**S-SV EMS Medical Director**

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**S-SV EMS Regional Executive Director**

**SUBJECT: EMT SCOPE OF PRACTICE**

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7. Provide initial prehospital emergency care of trauma.
  8. Administer oral glucose or sugar solutions.
  9. Extricate entrapped persons.
  10. Perform field triage.
  11. Transport patients.
  12. Set up for ALS / LALS procedures, under the direction of an Advanced EMT or Paramedic.
  13. Perform automated external defibrillation when authorized by an EMT AED service provider.
  14. Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.
- B. In addition to the activities authorized by section A of this policy, a certified EMT or a supervised EMT student in the prehospital setting and/or during interfacility transport may:
1. Monitor peripheral lines delivering intravenous glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement if:
    - a. The patient is non-critical and deemed stable by the transferring or base hospital physician and the physician approves transport by an EMT.
    - b. Nothing has been added to the intravenous fluids and, in the prehospital setting, no other advanced life support procedures have been initiated.
    - c. The EMT may monitor, maintain, and adjust, if necessary, in order to maintain a preset rate of flow and turn off the flow of intravenous fluid.
  2. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks foley catheters, tracheostomy tubes and/or indwelling vascular access lines, **excluding arterial lines**. Utilizing the following guidelines:
    - a. Nasogastric Tubes
      - Nasogastric tubes shall be clamped. No form of suction shall be allowed during transport.

**SUBJECT: EMT SCOPE OF PRACTICE**

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- A nasogastric tube shall be secured to the nose appropriately and shall also be secured to the patients clothing to prevent accidental dislodgement or patient discomfort.
  - Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
  - Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowlers position to help prevent the possibility of aspiration.
- b. Abdominal Tubes (Gastrostomy tubes, ureterostomy tubes, wound drains, etc.)
- EMTs shall check that abdominal tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
  - Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
  - Any dressing drainage shall be noted and charted.
  - Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.
- c. Foley Catheters
- Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
  - Amount and characteristics of urine shall be noted.
  - If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.
- d. Tracheostomy Tubes
- Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.

**SUBJECT: EMT SCOPE OF PRACTICE**

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- EMTs may suction **at the opening only** to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
  - If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile NaCl and gently reinsert it, or allow the patient to reinsert it if capable.
3. Transfer a patient that has a physician prescribed, locked down, patient operated medication pump.

**C. Optional Skills**

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

1. Use an Esophageal Tracheal Airway device (ETAD) on an unconscious patient with an absent gag reflex, who is apneic or has a respiratory rate less than 6/min, appears 16 years old or older and appears at least five (5) feet tall in accordance with S-SV Protocol 'Esophageal Tracheal Airway Device Treatment Guidelines', Reference No. 877.
2. Use a King Airway device on an unconscious patient with an absent gag reflex, who is apneic or has a respiratory rate less than 6/min, and appears at least four (4) feet tall in accordance with S-SV Protocol 'King Airway', Reference No. 1102.
3. Administration of epinephrine by auto-injector or for patients in severe distress for suspected anaphylaxis or asthma in accordance with S-SV Protocol 'EMT Administration of Epinephrine by Auto-Injector for Suspected Anaphylaxis &/or Severe Asthma', Reference No. 872.
4. Administration of atropine and pralidoxime chloride by auto-injector (Mark-I / DuoDote Kit) or preloaded syringe for nerve agent exposure in accordance with S-SV Protocol 'Nerve Agent Treatment', Reference No. E-8 .

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

**CROSS REFERENCES:**

Policy and Procedure Manual

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

**SUBJECT: EMT SCOPE OF PRACTICE**

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

- Service Provider Application Form, Addendum A
- Status Report Form, Addendum B
- Skill Check Documentation Record - Form, Addendum C

CQI Process: EMT Optional Skill, Reference No. 620-E

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

Esophageal Tracheal Airway Device Treatment Guidelines, Reference No. 877  
AED Treatment Guideline, Reference No. 895

Nerve agent treatment, Reference No. E-8

King Airway, Reference No. 1102

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 823

**SUBJECT: DO NOT RESUSCITATE (DNR)**

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## PURPOSE

To provide a mechanism to allow patients to refuse unwanted resuscitation attempts and ensure that patient's rights to control their own medical treatment are honored.

This policy defines a valid Do Not Resuscitate (DNR) directive and establishes the criteria, requirements and procedures to withhold resuscitative measures in the prehospital setting.

## AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.2

California Code of Regulations, Title 22, Division 9

Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Directives, (EMSA #111), California Emergency Medical Services Authority

## DEFINITIONS

- A. **Do Not Resuscitate (DNR):** Means no chest compressions, defibrillation, advanced airway, assisted ventilation, or cardiotoxic drugs. The patient shall receive full palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions; i.e., oropharyngeal suction and oxygen. Relief of choking caused by a foreign body is appropriate; however, if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
- B. **Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form:** An approved DNR form, developed by the California Emergency Medical Services Authority (EMSA) and the California Medical Association (CMA), that is used statewide for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest in the out of hospital setting. The Emergency Medical Services Prehospital DNR form must be signed and dated by a physician and patient/surrogate. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider. See 823-A for copy of EMSA/CMA DNR form.
- C. **POLST (Physician's Orders for Life Sustaining Treatment):** An approved form (usually bright pink in color) containing physician's orders designed to improve end-of-life care by converting patients' treatment wishes into medical

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**Effective Date: 06/01/2012**

**Date last Reviewed / Revised: 03/12**

**Next Review Date: 03/2015**

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**Approved:**

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**S-SV EMS Regional Executive Director**

**SUBJECT: DO NOT RESUSCITATE (DNR)**

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orders that are transferable throughout the health care system. See 823-B for copy of EMSA/California Coalition for Compassionate Care POLST form.

- D. **MedicAlert® DNR Wrist or Neck Medallion:** A MedicAlert® or other State EMSA approved wrist or neck medallion, permanently engraved with the words "Do Not Resuscitate - EMS", and a patient identification number.
- E. **California Durable Power of Attorney for Health Care (DPAHC):** Allows an individual to appoint an "agent/attorney-in-fact" to make health care decisions if they become incapacitated. The DPAHC must be immediately available. The agent/attorney-in-fact must be physically present and provide adequate identification. Decisions made by the agent/attorney-in-fact must be within the limits set by the DPAHC, if any.
- F. **"Advance Health Care Directive" or "Advance Directive" (AHCD):** Means either a power of attorney for health care or an individual health care instruction. The AHCD must be immediately available. The agent/attorney-in-fact must be physically present and provide adequate identification. Decisions made by the attorney-in-fact must be within the limits set by the Advanced Directive, if any.
- G. **"Agent or Attorney-In-Fact"** means an individual designated in a power of attorney for health care to make a health care decision for the principal/patient, regardless of whether the person is known as an agent or attorney-in-fact, or by some other term.
- H. **"Declaration" found in the California Natural Death Act:** A statement to physicians (not intended for prehospital providers) by an adult patient directing the withholding or withdrawal of life sustaining procedures in a terminal condition or permanent unconscious state.
- I. **"Living Will" or other form of documentation:** Communicates some sense of the patient's wishes that explicitly express that resuscitation is unwarranted or unwanted.

**S-SV EMS APPROVED DNR ORDERS FOR PREHOSPITAL PROVIDERS**

- A. Any one of the following DNR orders are approved and shall be honored, by prehospital providers:
  1. A fully executed original or photocopy of the Emergency Medical Services Prehospital Do Not Resuscitate (DNR) form.
  2. A fully executed original, or photocopy, of the POLST form.
  3. The patient is wearing an approved DNR wrist or neck medallion.
  4. If the patient's physician is present, s/he may verbally order DNR and immediately confirm the DNR order in writing in the PCR/patient's medical

**SUBJECT: DO NOT RESUSCITATE (DNR)**

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record. A telephone order by the patient's physician to the prehospital care provider is not acceptable.

5. A written or electronic DNR order by a physician. In order to be valid this type of DNR order shall consist of the following:
  - a. Patient's name
  - b. The words "Do Not Resuscitate" (or DNR) or "No Code"
  - c. The physician's signature or an RN signature verifying a valid verbal order from a physician on a physician order sheet
  - d. The date of the order

There are no other requirements for the DNR order, such as a prescribed form, a time or date of duration or a diagnosis.

**A. POWER OF ATTORNEY FOR HEALTH CARE**

A Power of Attorney for Health Care contained in an Advanced Health Care Directive (AHCD) or Durable Power of Attorney for Health Care (DPAHC), with the agent/attorney-in-fact physically present, and stating the patient refuses resuscitative measures. The agent/attorney-in-fact must provide adequate identification.

**PROCEDURE**

- A. All patients shall receive an immediate assessment/medical evaluation.
- B. Identify that the patient is the person named in the DNR order or Power of Attorney for Health care. This will normally require either the presence of a witness who can reliably identify the patient or the presence of an identification band/tag.
- C. When prehospital personnel respond to a patient in cardiopulmonary arrest BLS measures shall be initiated pending verification of a valid DNR order.
- D. Base/modified base hospital physicians retain authority for determining the appropriateness of resuscitation. When in doubt, resuscitation shall be initiated and the base/modified base hospital physician contacted immediately.
- E. If an S-SV approved DNR order is not available, prehospital personnel shall consult with the base/modified base hospital physician to discuss the validity or applicability of forms presented other than those approved for use in the S-SV EMS Region. Examples of other DNR Directives not approved for prehospital care in the S-SV region are:
  1. Individual health care instructions contained in an Advanced Health Care Directive.

**SUBJECT: DO NOT RESUSCITATE (DNR)**

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2. Declaration found in the California Natural Death Act.
  3. Living Will or other forms of documentation.
- F. If there is any objection or disagreement by family members/caretakers regarding withholding resuscitation, or if prehospital personnel have any reservations regarding the validity of the DNR order, resuscitation shall begin immediately and contact with the base/modified base hospital physician shall be made for further direction.
- G. If a patient has a valid DNR, but resuscitation was started prior to arrival of the EMS responder, CPR can be discontinued.
- H. If the patient is conscious and states that s/he wishes resuscitative measures, then the DNR form shall be ignored.

**DOCUMENTATION**

- A. A copy of the DNR form shall be included in the electronic Patient Care Report (ePCR), along with other appropriate documentation. The DNR form will be incorporated into the medical record at the receiving or base hospital.
- B. If the patient is wearing a MedicAlert® DNR bracelet or neck medallion, record the MedicAlert® number in the ePCR documentation.
- C. When DNR orders are noted in the patient's written or electronic medical record, a copy of the order should be attached to the ePCR. If copies are unavailable, the prehospital care provider shall document in the ePCR that a written or electronic DNR order was present, including the name of the physician, date signed or entered and other appropriate information.
- D. Document the base/modified base physician name in the ePCR narrative, if consulted.
- E. When possible, a copy of the DPAHC or AHCD or other DNR directives should be included in the ePCR. If copies are unavailable, the prehospital care provider shall document in the ePCR narrative the type of written DNR directive that was present, including the date signed and other appropriate information.
- F. If patient transport is undertaken, the DNR order is to be taken with the patient to the receiving facility.
- G. All circumstances surrounding the incident and the validation criteria used to honor the DNR request shall be documented in the narrative portion of the ePCR.

**SUBJECT: DO NOT RESUSCITATE (DNR)**

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**CROSS REFERENCES**

Policy and Procedure Manual

EMSA / CMA DNR Form, Reference No. 823-A

POLST Form, Reference No 823-B

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

Determination of Death - Public Safety, EMT, AEMT & Paramedic Personnel,  
Reference No. 820

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



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

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

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

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

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

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

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

\_\_\_\_\_  
Date

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

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

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Telephone

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

**PREHOSPITAL DNR REQUEST FORM**

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# 2011 California POLST Form

**Effective April 1, 2011**

In order to maintain continuity throughout California, please follow these instructions:

**\*\*\* Copy or print POLST form on 65# Cover Ultra Pink card stock. \*\*\***

Mohawk BriteHue Ultra Pink card stock is available online and at some retailers. See below for suggested online vendors.

Ultra Pink paper is used to distinguish the form from other forms in the patient's record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.

Suggested online vendors for Ultra Pink card stock:

**Med-Pass** - [www.med-pass.com](http://www.med-pass.com)

(also carries pre-printed POLST forms on Ultra Pink card stock)

**Boyd's Imaging Products** - [www.iboyds.com](http://www.iboyds.com)

**Mohawk Paper Store** - [www.mohawkpaperstore.com](http://www.mohawkpaperstore.com)



EMSA #111 B  
(Effective 4/1/2011)

# Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

## **A** CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When 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 person has pulse and/or is breathing.*

Check One

- Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital only if comfort needs cannot be met in current location.**
- Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- Transfer to hospital only if comfort needs cannot be met in current location.**
- Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

Additional Orders: \_\_\_\_\_

## **C** ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

- No artificial means of nutrition, including feeding tubes. Additional Orders: \_\_\_\_\_
- Trial period of artificial nutrition, including feeding tubes. \_\_\_\_\_
- Long-term artificial nutrition, including feeding tubes. \_\_\_\_\_

## **D** INFORMATION AND SIGNATURES:

**Discussed with:**       Patient (Patient Has Capacity)       Legally Recognized Decisionmaker

Advance Directive dated \_\_\_\_\_ available and reviewed → Health Care Agent if named in Advance Directive:

Advance Directive not available      Name: \_\_\_\_\_

No Advance Directive      Phone: \_\_\_\_\_

**Signature of Physician**  
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: (required)		Date:

**Signature of Patient or Legally Recognized Decisionmaker**  
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:	
Address:	Daytime Phone Number:	Evening Phone Number:

# HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

## Patient Information

Name (last, first, middle):	Date of Birth:	Gender: <b>M</b> <b>F</b>
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## Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:
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## Additional Contact

Name:	Relationship to Patient:	Phone Number:
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## Directions for Health Care Provider

### Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- 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 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.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- 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 person who has chosen "Do Not Attempt Resuscitation."

#### Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," 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 Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" 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 person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, 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, based on the known desires of the individual or, if unknown, the individual'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](http://www.caPOLST.org).

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 844

**SUBJECT: ALS / LALS TRANSFER OF PATIENT CARE**

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## **PURPOSE**

To ensure a mechanism exists for the appropriate transfer of patient care from ALS / LALS personnel to other prehospital care providers.

## **AUTHORITY**

California Health and Safety Code, Division 2.5, Section 1791.220

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

## **POLICY**

- A. Patient assessment and care shall be started by the first arriving ALS / LALS unit Advanced EMT, paramedic or flight nurse.
- B. The first on duty ALS / LALS licensed and accredited or certified responder who makes patient contact at the scene of an emergency shall be the primary care provider for that patient until such responsibility is transferred to another Advanced EMT, paramedic, flight nurse or EMT partner.
- C. All ALS / LALS personnel on scene have a duty to provide the primary care provider with recommendations and assistance, to ensure the best possible patient care as logistics permit and circumstances require.
- D. The primary care provider shall provide other assisting ALS / LALS personnel who arrive on scene with all appropriate patient care information.
- E. If there are significant differences regarding the transfer of care or correct course of treatment between ALS / LALS providers, base / modified base hospital consultation shall be utilized to determine the appropriate treatment.

## **PROCEDURE**

### **A. PARAMEDIC TO PARAMEDIC:**

- 1. Paramedics are authorized to transfer the role of primary paramedic to another paramedic when patient condition permits.

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**Effective Date: 06/01/2012**

**Date last Reviewed / Revised: 02/12**

**Next Review Date: 02/2015**

**Page 1 of 5**

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**SUBJECT: ALS / LALS TRANSFER OF PATIENT CARE**

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2. The primary paramedic shall maintain the lead responsibility and accompany the patient during transport in the following circumstances:
  - a. When the patient is determined to be critical, with the exception of the following special circumstances:
    - Paramedics who are functioning in an S-SV EMS Agency approved specialized role (Tactical Medic, Fireline Medic, Bike Medic) may transfer care of a critical patient to another paramedic when necessary.
    - Paramedics may transfer care of a critical patient to an ALS Flight Crew, including paramedic flight personnel, when necessary.
  - b. When the receiving paramedic refuses transfer of care due to the patient's condition or complexity of treatment.

If there are significant differences regarding the transfer of care or correct course of treatment between ALS providers, base / modified base hospital consultation shall be utilized to determine the appropriate treatment.

3. The primary paramedic that decides to transfer care to another paramedic shall:
  - a. Provide complete patient assessment and treatment information to the Paramedic accepting responsibility for the patient.
  - b. Ensure the completion of an electronic patient care record (ePCR) per Agency policy. The narrative portion of the ePCR shall include; the time of transfer, name of paramedic personnel and ALS provider accepting transfer, and the time of the transport unit's departure from the scene.

**B. ADVANCED EMT TO ADVANCED EMT:**

1. Advanced EMTs are authorized to transfer the role of primary Advanced EMT to another Advanced EMT when patient condition permits.
2. The primary Advanced EMT shall maintain the lead responsibility and accompany the patient during transport in the following circumstances:
  - a. When the patient is determined to be critical
  - b. When the receiving Advanced EMT refuses transfer of care due to the patient's condition or complexity of treatment.

If there are significant differences regarding the transfer of care or correct course of treatment between LALS providers, base / modified base hospital consultation shall be utilized to determine the appropriate treatment.

**SUBJECT: ALS / LALS TRANSFER OF PATIENT CARE**

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3. The primary Advanced EMT that decides to transfer care to another Advanced EMT shall:
  - a. Provide complete patient assessment and treatment information to the Advanced EMT accepting responsibility for the patient.
  - b. Ensure the completion of an electronic patient care record (ePCR) per Agency policy. The narrative portion of the ePCR shall include; the time of transfer, name of Advanced EMT personnel and LALS provider accepting transfer, and the time of the transport unit's departure from the scene.

**C. ADVANCED EMT TO GROUND PARAMEDIC:**

1. Advanced EMTs shall provide a verbal and written report when able (in some cases a triage tag) to the arriving ground paramedic.
2. Patient care shall be transferred to the ground paramedic as soon as possible after their arrival on scene.
3. The ground paramedic shall provide a report and ETA to the receiving hospital staff while enroute.
4. Advanced EMTs shall ensure the completion of an electronic patient care record (ePCR) per Agency policy. The narrative portion of the ePCR shall include; the time of transfer, name of paramedic ground personnel and EMS ground provider accepting transfer, and the time of the transport unit's departure from the scene.

**D. ADVANCED EMT OR PARAMEDIC TO ALS FLIGHT CREW:**

1. Ground Advanced EMT and paramedic personnel shall provide a verbal and written report when able (in some cases a triage tag) to the arriving flight crew.
2. Patient care may not be transferred to ALS flight crews until they are ready to accept care of the patient. This shall permit the flight crew to prepare for lift-off and begin any additional interventions.
3. The ALS flight crew shall provide a report and ETA to the receiving hospital staff while enroute.
4. Ground Advanced EMT and Paramedic personnel shall ensure the completion of an electronic patient care record (ePCR) per Agency policy. The narrative portion of the ePCR shall include; the time of transfer, name of ALS Flight personnel and EMS Air provider accepting transfer, and the time of the transport unit's departure from the scene.

**SUBJECT: ALS / LALS TRANSFER OF PATIENT CARE**

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**E. RN FLIGHT NURSE TO AEMT OR PARAMEDIC:**

1. Flight Nurses are authorized to transfer the role of primary care provider to an Advanced EMT or paramedic when the care does not exceed the Advanced EMTs or paramedic's scope of practice, and patient condition permits.
2. The flight nurse shall maintain the lead responsibility and accompany the patient during transport in the following circumstances:
  - a. When the patient is determined to be critical.
  - b. When the receiving Advanced EMT or paramedic refuses transfer of care due to the patient's condition or complexity of treatment.
3. The flight nurse that decides to transfer care to an Advanced EMT or paramedic shall:
  - a. Provide complete patient assessment and treatment information to the Advanced EMT or paramedic accepting responsibility for the patient.
  - b. Ensure the completion of an electronic patient care record (ePCR) per Agency policy. The narrative portion of the ePCR shall include; the time of transfer, name of Advanced EMT or paramedic personnel and ALS / LALS provider accepting transfer, and the time of the transport unit's departure from the scene.

**F. ADVANCED EMT OR PARAMEDIC TO EMT PARTNER:**

The Advanced EMT or paramedic is responsible for the initial patient history, assessment and reassessment. The Advanced EMT or paramedic is ultimately responsible for all aspects of patient care rendered. Patient care may be delegated to an EMT partner, pursuant only to the requirements as defined in this policy.

1. Prior to delegation of patient care to an EMT partner:
  - a. The Advanced EMT or paramedic shall be responsible for a complete initial assessment and patient history.
  - b. Delegation of patient care can occur only if the patient does not meet ALS / LALS treatment criteria including, but not limited to, the following:
    - All patients refusing assessment, treatment, or transportation.
    - All patients where ALS treatment is indicated according to S-SV EMS policies or treatment protocols.

**SUBJECT: ALS / LALS TRANSFER OF PATIENT CARE**

- All trauma patients as defined by S-SV EMS Trauma Triage Criteria policy (Reference No. 860).
  - All 5150 patients.
  - Any patient who, in the opinion of the ALS / LALS provider, requires the additional input or judgment of the Advanced EMT / paramedic or base / modified base hospital for appropriate management.
  - All patients in active labor or pregnant patients with greater than 20 week's gestation, with an obstetric complaint.
- c. The Advanced EMT or paramedic is responsible to ensure that the documentation of his/her initial assessment and patient history is completed on the PCR.

**CROSS REFERENCES**

Policy and Procedure Manual

Prehospital Documentation, Reference No. 605.

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

Medical Control at The Scene of an Emergency, Reference No. 835.

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

Trauma Triage Criteria, Reference No. 860

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 851

**SUBJECT: TREATMENT / TRANSPORT OF MINORS**

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## **PURPOSE**

To describe the guidelines for treatment and/or transport of a patient under the age of eighteen (18).

## **AUTHORITY**

California Health and Safety Code, Division 2.5

California Code of Regulations, Title 22, Division 9

California Welfare and Institution Code, Sections 305 and 625

## **POLICY**

- A. **Minor:** A person less than eighteen (18) years of age.
- B. **Minor not requiring parental consent:** A person less than eighteen (18) years of age who meets one or more of the following criteria:
  - 1. Has an emergency medical condition and parent or legal guardian is not available
  - 2. Is married or previously been married
  - 3. Is on active duty in the military
  - 4. Is fifteen (15) years of age or older, living separate and apart from his or her parents and managing his or her own financial affairs
  - 5. Is twelve (12) years of age or older and in need of medical care for a contagious reportable disease/condition or for substance abuse
  - 6. Is an emancipated minor (decreed by a court, may be verified by DMV identification card)
  - 7. Is pregnant and requires medical care related to the pregnancy
  - 8. Is in need of medical care for sexual assault

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**Effective Date: 06/01/2012**  
**Next Review Date: 03/2015**  
**Approved:**

**Date last Reviewed / Revised: 03/12**  
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**SUBJECT: TREATMENT / TRANSPORT OF MINORS**

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- C. **Legal Guardian:** A person who is granted custody or conservatorship of another person by a court of law.
- D. **Emergency:** A condition or situation in which an individual has a need for immediate medical attention or where the potential for need is perceived by EMS personnel or a public safety agency.

**PRINCIPLES**

**CONSENT:**

- A. **Actual Consent:** Treatment or transport of a minor child shall be with the verbal or written consent of a parent or legal guardian.
- B. **Implied Consent:** In the absence of a parent or legal guardian, emergency treatment and/or transport of a minor may be initiated without consent.

**PROCEDURE**

- A. In the absence of a parent or legal guardian, minors with an emergency condition shall be treated and transported to the health facility most appropriate to the needs of the patient (e.g., Trauma Center, etc.).
- B. Hospital or provider agency personnel shall make every effort to inform a parent or legal guardian of where their child has been transported.
- C. If prehospital care personnel believe a parent or legal guardian of a minor is making a decision which appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

**CROSS REFERENCES**

Policy and Procedure Manual

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

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 860

**SUBJECT: TRAUMA TRIAGE CRITERIA**

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## **PURPOSE:**

To identify those patients who are at greatest risk for severe injury and determine the most appropriate facility to transport persons with different injury types and severities.

## **AUTHORITY:**

California Health & Safety Code, Division 2.5; Chapter 6, Article 2.5, Section 1798.160 et seq.

California Code of Regulations, Title 22, Division 9, Chapter 7

Centers for Disease Control and Prevention 'Morbidity and Mortality Weekly Report' (MMWR), Recommendations and Reports, January 13, 2012 / Vol. 61 / No. RR-01, 'Guidelines for Field Triage of Injured Patients, Recommendation of the National Expert Panel on Field Triage, 2011':

[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6101a1.htm?s\\_cid=rr6101a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6101a1.htm?s_cid=rr6101a1_w)

## **PRINCIPLES:**

The trauma triage criteria indicate high-risk factors for serious traumatic injuries. Trauma patients meeting triage criteria should be transported as soon as possible, and time on scene should be limited. Procedures at the scene should be limited to triage, patient assessment, airway management, control of external hemorrhage and appropriate immobilization. Additional interventions should be completed en route with the exception of those incidents requiring prolonged extrication.

## **TRAUMA CENTER LEVELS**

**Level I:** A Level I Trauma Center has the greatest amount of resources and personnel for care of the injured patient. Typically, it is also a tertiary medical care facility that provides leadership in patient care, education and research for trauma, including prevention programs.

**Level II:** A Level II Trauma Center offers similar resources as a Level I facility, differing only by the lack of research activities for a Level I designation.

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**Page 1 of 5**

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**SUBJECT: TRAUMA TRIAGE CRITERIA**

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**Level I and II Pediatric:** Level I and II Pediatric Trauma Centers focus specifically on pediatric trauma patients. Level I Pediatric Trauma Centers require some additional pediatric specialties and are research and teaching facilities.

**Level III:** A Level III Trauma Center is capable of assessment, resuscitation and emergency surgery, if warranted. Injured patients are stabilized before transfer, if indicated, to a facility with a higher level of care according to pre-existing arrangements.

**Level IV:** A Level IV Trauma center is capable of providing 24-hour physician coverage, resuscitation and stabilization to injured patients before they are transferred, if indicated.

**PATIENT DESTINATION:**

- A. Patients with an unmanageable airway shall be transported to the closest receiving hospital for airway stabilization.
- B. For any patient who is found to meet at least one of the Anatomic or Physiologic Trauma Triage Criteria:
  - 1. If the time closest designated Trauma Center is a Level I or Level II Trauma Center, transport directly to the Level I or Level II Trauma Center.
  - 2. If the time closest designated trauma center is a Level III Trauma Center, contact the Level III Trauma Center for a destination decision.
- C. If a trauma patient meets Mechanism of Injury Trauma Criteria only, with or without meeting any of the Special Considerations Criteria, prehospital personnel shall contact the closest base/modified base hospital for a destination decision.
- D. If a trauma patient meets the Special Considerations Criteria only, without meeting any of the Anatomic, Physiologic or Mechanism of Injury trauma triage criteria, contact with the closest base/modified base hospital shall be made for a destination decision when prehospital personnel determine that transport to a trauma center may be in the best interest of the patient.
- E. The use of EMS aircraft for transport of trauma patients should provide a clinically significant reduction in arrival time to the most appropriate designated trauma center. If the total time for air transport exceeds the ground ambulance arrival time, air transport may not be indicated.
- F. Pediatric Trauma Patient Destination
  - 1. When ground ambulance or EMS aircraft (if utilized) transport times do not exceed 45 minutes, all children  $\leq$  14 years of age who meet Anatomic and/or

**SUBJECT: TRAUMA TRIAGE CRITERIA**

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Physiologic Trauma Triage Criteria should be transported directly to a designated pediatric trauma center.

2. If a pediatric patient meets criteria for direct transport to a designated pediatric trauma center, but the patient's condition is so critical that any additional transport time may jeopardize the patient's life, the patient shall be transported to the closest designated trauma center.

G. Prehospital personnel shall notify the designated receiving trauma center of the patient's pending arrival as soon as possible.

**TRAUMA TRIAGE CRITERIA:**

**A. Physiologic Criteria:**

1. Respiratory Rate  $< 10$  or  $> 29$  breaths per minute ( $< 20$  in infant aged  $< 1$  year) or need for ventilatory support, or
2. Glasgow Coma Score  $\leq 13$ , or
3. Systolic Blood Pressure  $< 90$

**B. Anatomic Criteria:**

1. All penetrating injuries to the head, neck, chest, torso, and extremities proximal to the elbow or knee
2. Chest wall instability or deformity (e.g. flail chest)
3. Two or more proximal long-bone fractures
4. Paralysis
5. Pelvic fractures
6. Amputation proximal to wrist or ankle
7. Crushed, degloved or mangled or pulseless extremity
8. Open or depressed skull fracture

**C. Mechanism of Injury Criteria:**

1. High-risk auto crash (one or more of the following):
  - a. Ejections (partial or complete) from automobile
  - b. Death in the same passenger compartment

**SUBJECT: TRAUMA TRIAGE CRITERIA**

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- c. Intrusion, including roof: > 12 inches at occupant site or > 18 inches at any site
2. Non-Automotive crash > 20 mph including, but not limited to: motorcycle, ATV, go-cart, bicycle, skateboard, watercraft and aircraft
3. Auto vs Pedestrian / Bicycle: thrown, run over, or with significant (> 20 mph) impact
4. Adults who fall > 20 feet
5. Children who fall > 10 feet or two to three times the height of the child
6. Other high energy impact

**D. Special Considerations**

1. Age:
  - a. Adults > 55 years of age
    - SBP <110 might represent shock after 65 years of age
    - Low impact mechanism (e.g. ground level falls) might result in severe injury.
  - b. Children ≤ 14 years of age
    - Children should be triaged to pediatric capable trauma centers when possible
2. Anticoagulation or bleeding disorders
  - Patients with head injury are at high risk for rapid deterioration
3. Burns:
  - a. With trauma mechanism: Triage to trauma center
  - b. Without trauma mechanism: Triage to burn facility
4. Pregnancy > 20 weeks
5. EMS provider judgment in conjunction with medical control

**TRAUMA REGISTRY:**

All hospitals receiving trauma patients from the S-SV EMS Region shall supply data to the S-SV EMS Trauma Registry.

**SUBJECT: TRAUMA TRIAGE CRITERIA**

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**GLASGOW COMA SCALE (GCS): Adult & Pediatric Combined GCS**

**Note: Modifications for age appropriate response for infant/young child are typed in bold print.**

<b>GLASGOW COMA SCORE</b>		
<b>EYE OPENING RESPONSE</b>	<b>BEST VERBAL RESPONSE</b>	<b>BEST MOTOR RESPONSE</b>
4 pts = Open spontaneously	5 pts = Oriented & converses Appropriate words and phrases <b>Cries appropriately, coos, babbles</b>	6 pts = Obeys commands <b>Normal spontaneous movement</b>
3 pts = To verbal stimuli <b>To speech, to shout</b>	4 pts = Disoriented & converses <b>Irritable cry</b>	5 pts = Localizes pain <b>Withdraws to touch</b>
2 pts = To painful stimuli	3 pts = Inappropriate words <b>Inappropriate crying/screaming</b>	4 pts = Flexion withdrawal <b>Withdraws to pain</b>
1 pt = No response	2 pts = Incomprehensible sounds/words <b>Grunts</b>	3 pts = Flexion abnormal (decorticate)
	1 pt = No response	2 pts = Extension (decerebrate)
		1 pt = No response
Risk of injury is high with GCS < 14    COMA is defined by GCS ≤ 8 Any patient with a GCS ≤ 8, consider intubation and hyperventilate at 20 to 24 breaths per minute to reduce cerebral swelling.		

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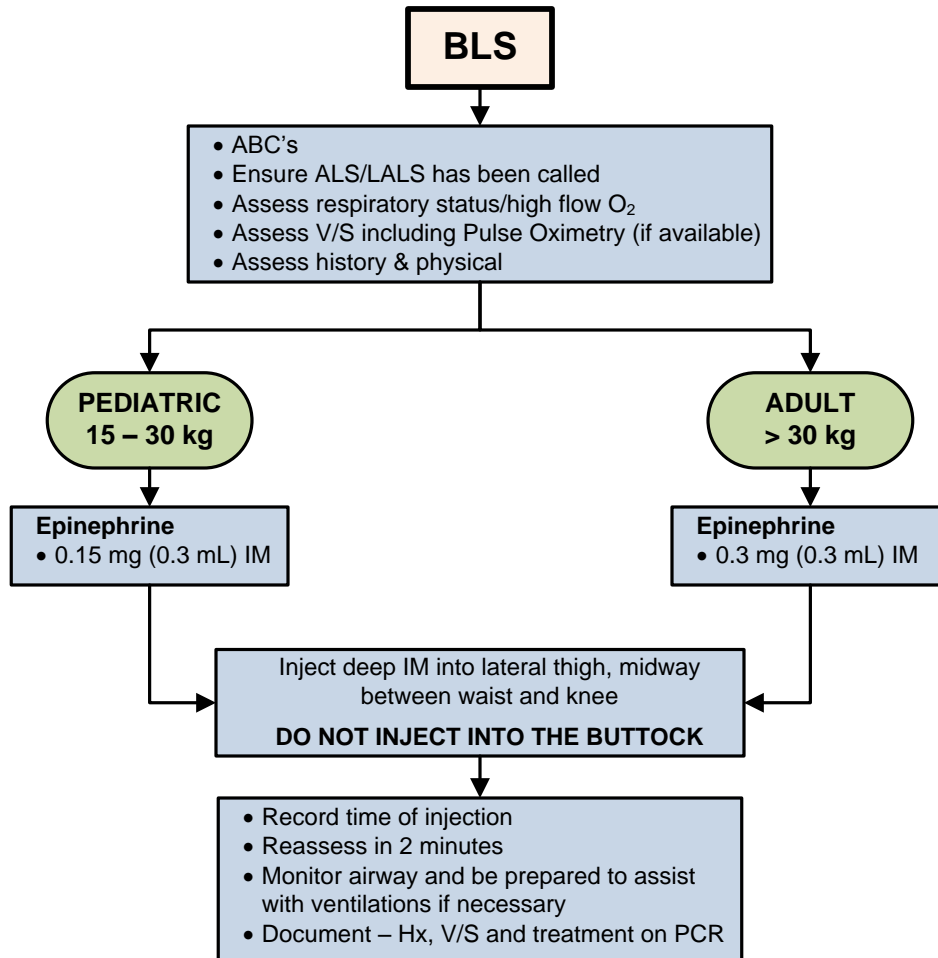
**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**EMT OPTIONAL SKILL**  
**REFERENCE NO. 872**

**SUBJECT: EMT ADMINISTRATION OF EPINEPHRINE BY AUTO-INJECTOR FOR SUSPECTED ANAPHYLAXIS &/OR SEVERE ASTHMA**

Candidates for the administration of epinephrine by optional skill approved EMTs are:

- Patients in SEVERE DISTRESS who may have a history of an allergy, with suspected exposure to a known allergen, and experiencing anaphylaxis or asthma with one or more of the following symptoms:
  - Stridor
  - Bronchospasm / wheezes / diminished breath sounds
  - Severe respiratory distress
  - Shock (SBP < 90)
  - Edema of tongue, lips and/or face



**NOTE:** For stability purposes, approximately 1.7 mL remains in the auto-injector after injection.  
 Do not use the auto-injector if the solution is discolored or contains a precipitate.

Effective Date: 06/01/2012  
 Next Review Date: 03/2015  
 Approved by:

Date last reviewed revised: 03/12  
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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 890

## SUBJECT: COMMUNICATION FAILURE

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### PURPOSE

To define the specific conditions under which a Paramedic or Advanced EMT may utilize Advanced Life Support (ALS) and Limited Advanced Life Support (LALS) drugs and procedures for patient care, in the event of communication failure.

### AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.84, 1797.185, 1797.220, 1798, 1798.100, 1798.102

California Code of Regulations, Title 22, Division 9

### POLICY

In the event that a Paramedic or Advanced EMT at the scene of an emergency attempts direct voice contact with a base hospital but cannot establish or maintain that contact:

- A. The Paramedic or Advanced EMT may initiate necessary ALS / LALS procedures specified in the approved S-SV EMS policies and protocols.
- B. Base / modified base contact is required to perform the procedures(s) and/or to administer medication(s) that are identified in S-SV policy/protocol as “**Base / Modified Base Hospital Physician Order Only.**” In the event of communication failure those procedures / medications **shall not** be performed / administered.

### PROCEDURE

In each instance where ALS / LALS procedures are initiated or attempted under the conditions specified for communication failure, the Paramedic or Advanced EMT shall:

- A. Attempt to establish base hospital contact throughout the call, as circumstances permit.
- B. Immediately upon voice contact, provide a verbal report to the base hospital physician or mobile intensive care nurse.

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**Effective Date: 06/01/2012**  
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**Approved:**

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**SUBJECT: COMMUNICATION FAILURE**

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**EXCEPTION:**

The Paramedic or Advanced EMT, functioning within a modified base hospital response area, renders patient care based on S-SV approved policy/protocol (standing orders) without “on-line” medical control.

The following procedures are currently identified as “**Base/Modified Hospital Physician Order Only**”:

1. Chemical restraint of combative patients with midazolam (Reference No. 852).
2. Terminating resuscitative efforts utilizing either the BLS or ALS termination of resuscitation criteria if no ROSC in an adult pulseless arrest patient (Reference No. C-1).
3. The administration of activated charcoal (Reference No. M-5)
4. The activation and use of the Nerve Agent Treatment Protocol (Reference No. E-8).

**CROSS REFERENCES:**

Policy and Procedure Manual

Modified Base Hospital, Reference No. 305

Base Hospital Contact, Reference No. 812

Violent Patient Restraint Mechanisms, Reference No. 852

Pulseless Arrest, Reference No. C-1

Ingestions and Overdoses, Reference No. M-5

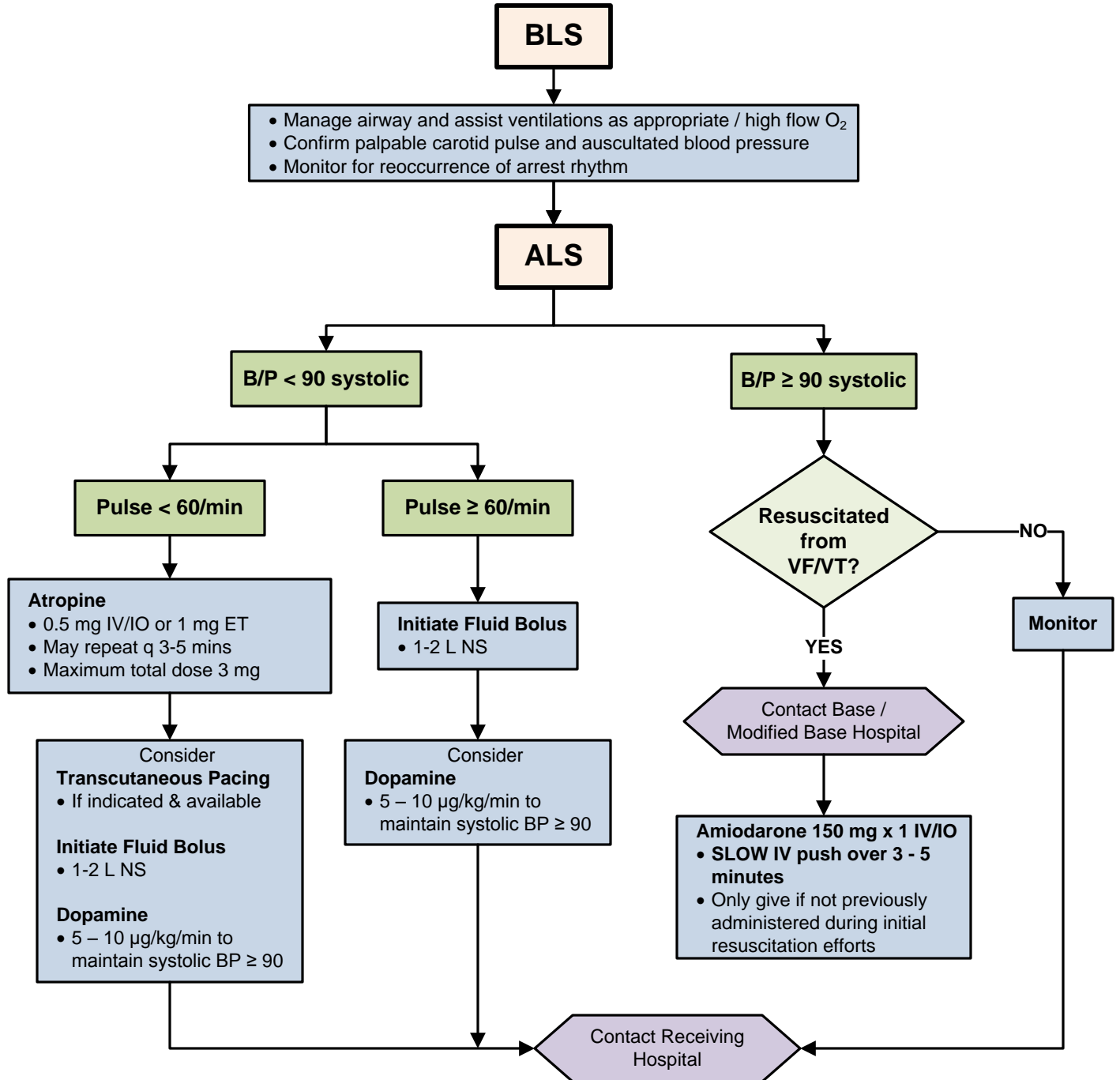
Nerve Agent Treatment, Reference No. E-8



**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**CARDIOVASCULAR**  
**REFERENCE NO. C-5**

**SUBJECT: RETURN OF SPONTANEOUS CIRCULATION (ROSC)**



Effective Date: 06/01/2012  
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Date last reviewed revised: 02/12  
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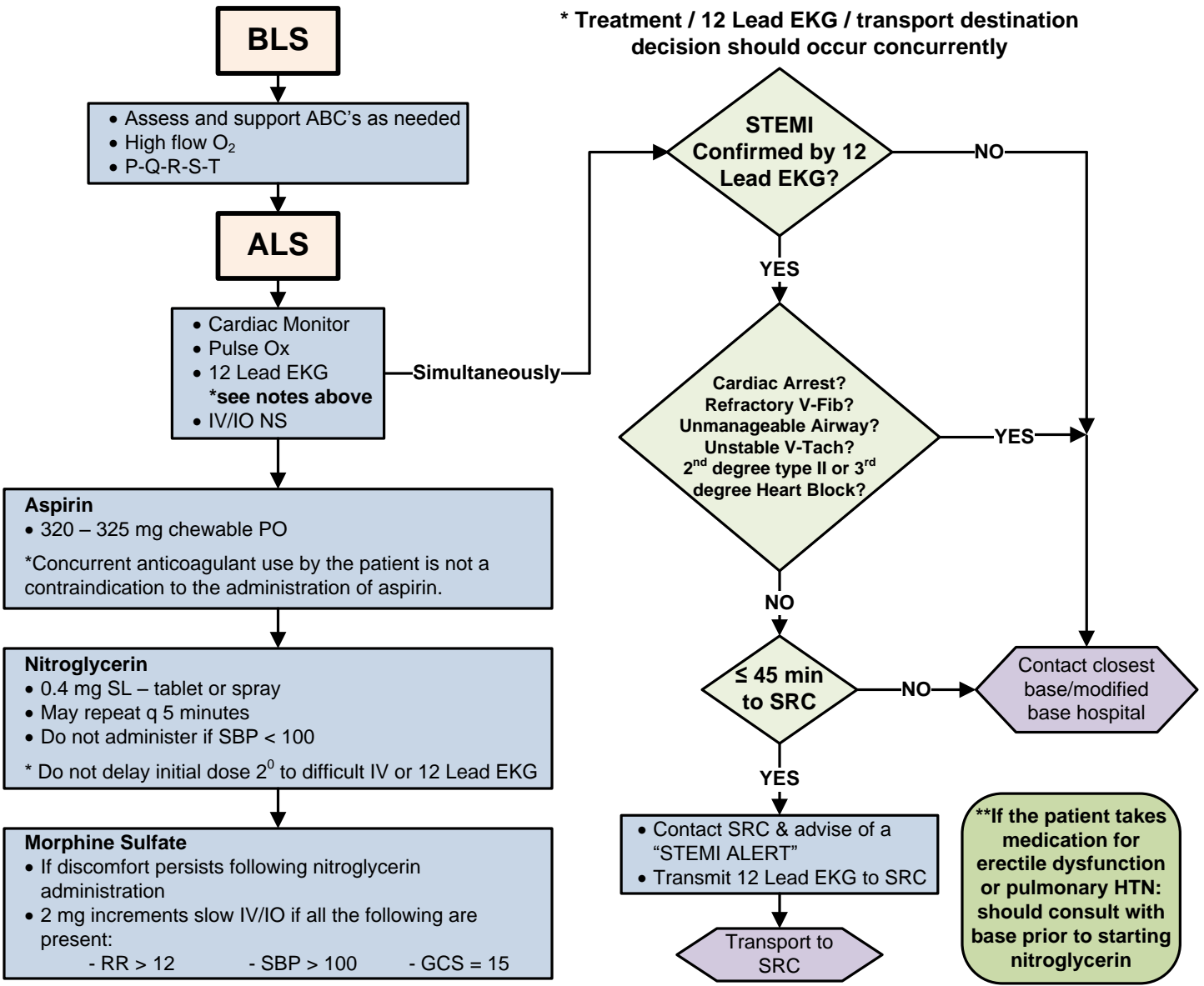


**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**CARDIOVASCULAR  
REFERENCE NO. C-8**

**SUBJECT: CHEST PAIN OR SUSPECTED SYMPTOMS OF CARDIAC ORIGIN**

- If available, a 12 Lead EKG shall be performed as part of a complete patient assessment.
- If not detrimental to the patient’s condition, the initial 12 Lead should be performed prior to medication administration.
- All 12 Lead EKG’s performed shall include a patient name or other unique patient identifier that is input into the monitor and printed on the EKG strip. The patient identification information shall be entered prior to EKG transmission.
- All patients with a 12 Lead EKG that shows a computer read out consistent with an acute ST elevation MI (i.e. \*\*\*Acute MI Suspected\*\*\*) shall be transported directly to the closest designated STEMI Receiving Center (SRC) if the transport time to that receiving center is ≤ 45 minutes. Early contact with the closest base/modified base hospital shall be made for any STEMI patient who is outside the SRC 45 minute transport time catchment area.



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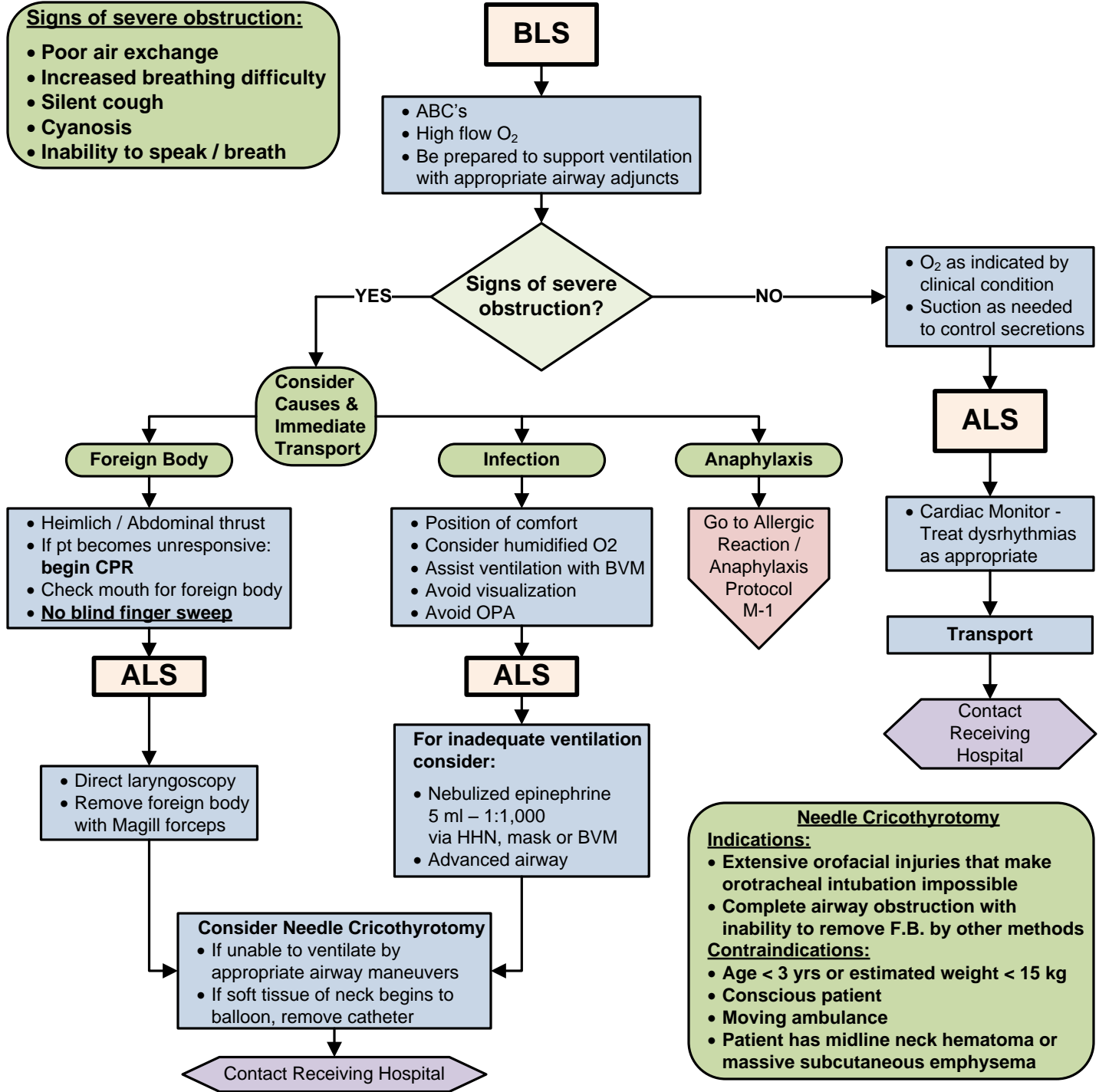
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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**RESPIRATORY  
REFERENCE NO. R-1**

**SUBJECT: AIRWAY OBSTRUCTION**



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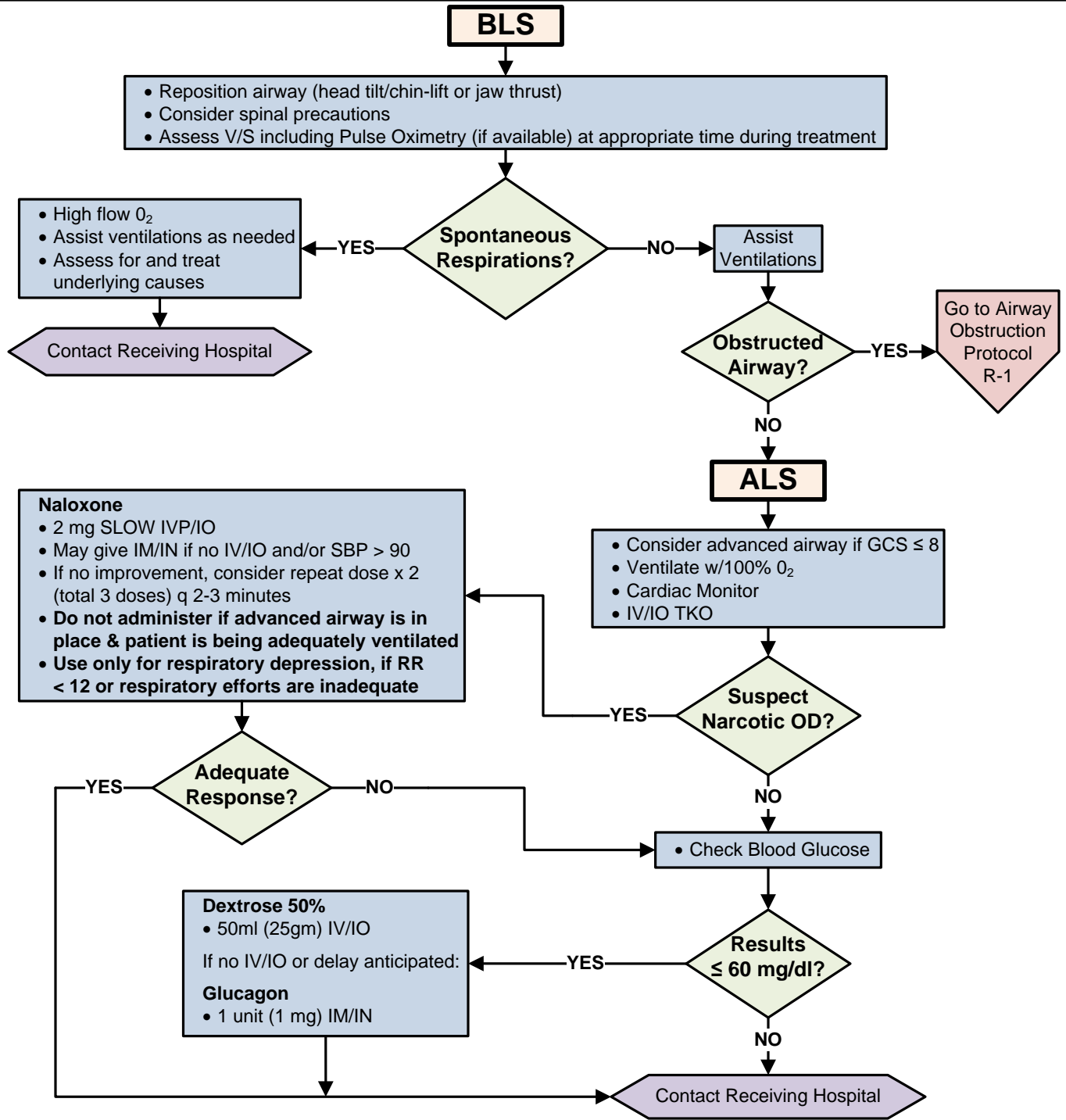
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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**RESPIRATORY  
REFERENCE NO. R-2**

**SUBJECT: RESPIRATORY ARREST**



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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**MEDICAL  
REFERENCE NO. M-3**

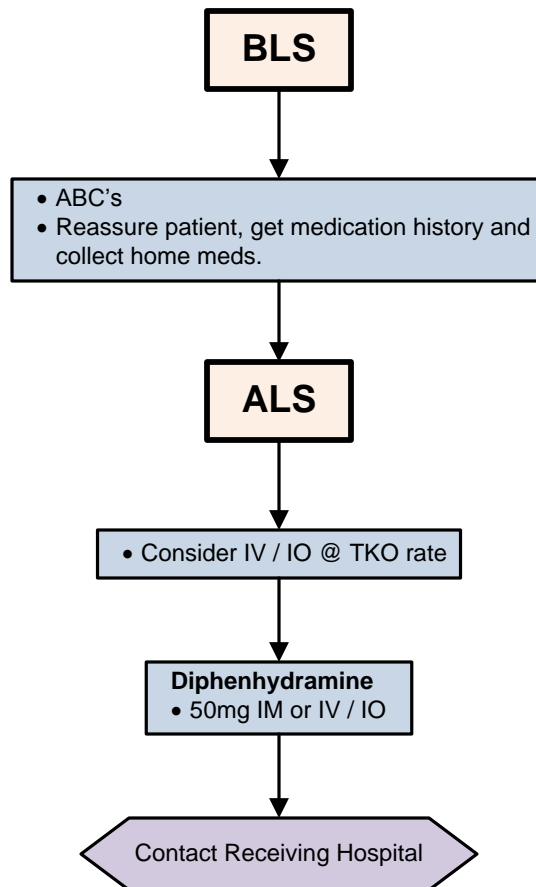
**SUBJECT: PHENOTHIAZINE / DYSTONIC REACTION**

• **Assessment:**

- History includes possible ingestion of phenothiazines
- Symptoms often mistaken for a seizure disorder or tetany

• **Signs and Symptoms**

- Facial Grimaces
- Protruding tongue / Jaw muscle spasm
- Oculogyric crisis (circular movement of the eyeballs)
- Spasms of the back muscles, causing the head and legs to bend backward and the trunk to arch up
- Anxiety / Restlessness
- Torticollis (twisting of the neck)



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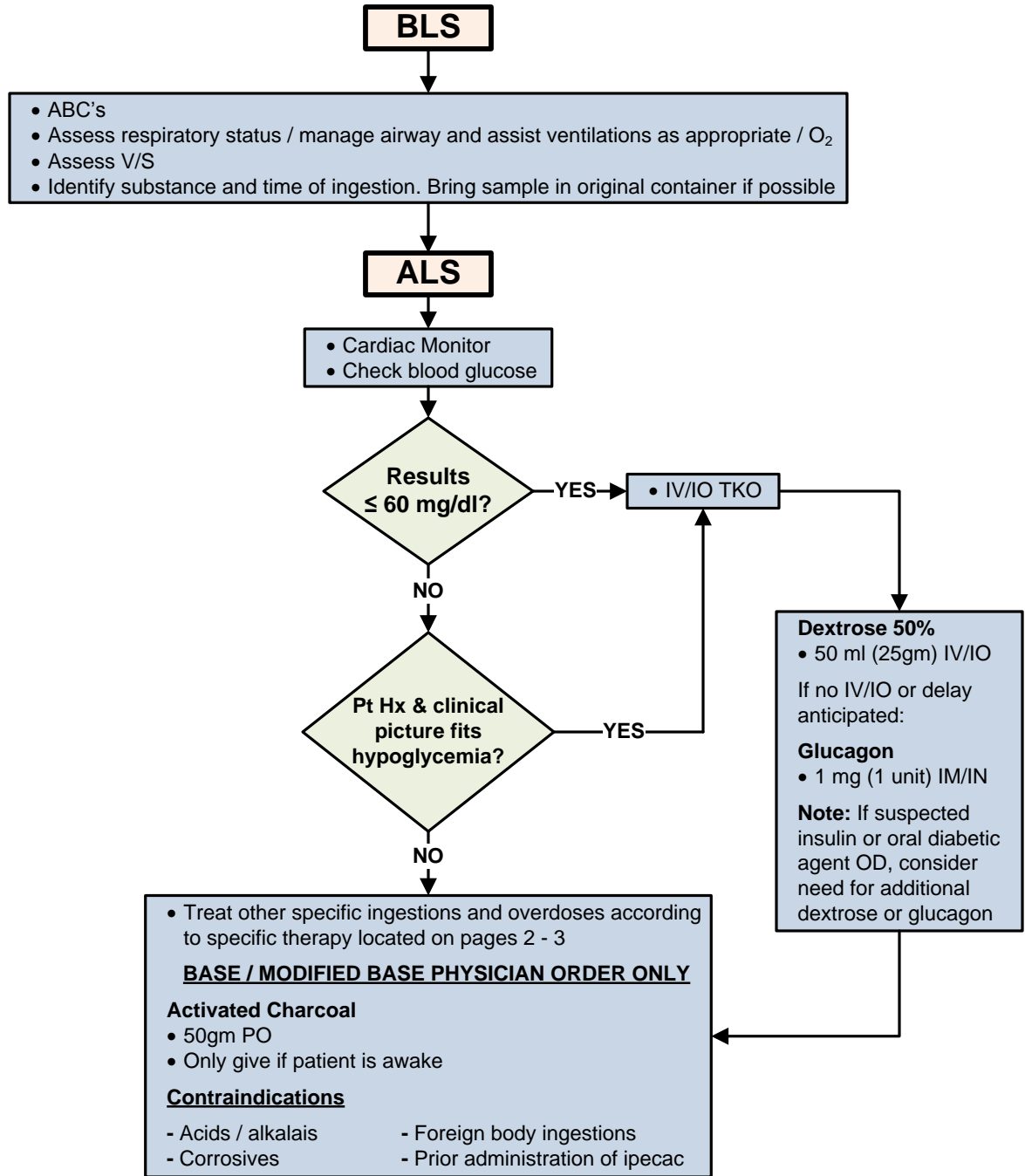


**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**MEDICAL  
REFERENCE NO. M-5**

**SUBJECT: INGESTIONS AND OVERDOSES**

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



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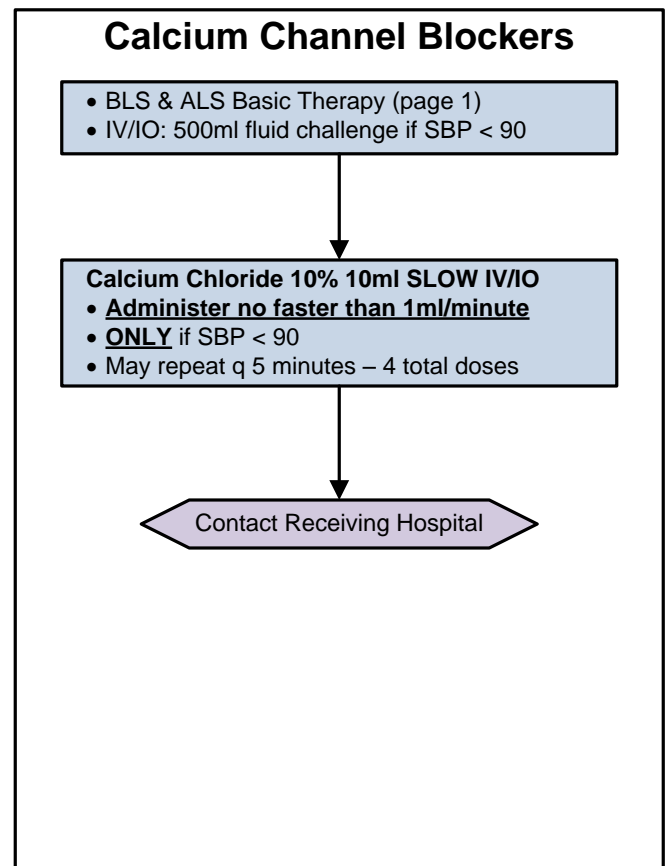
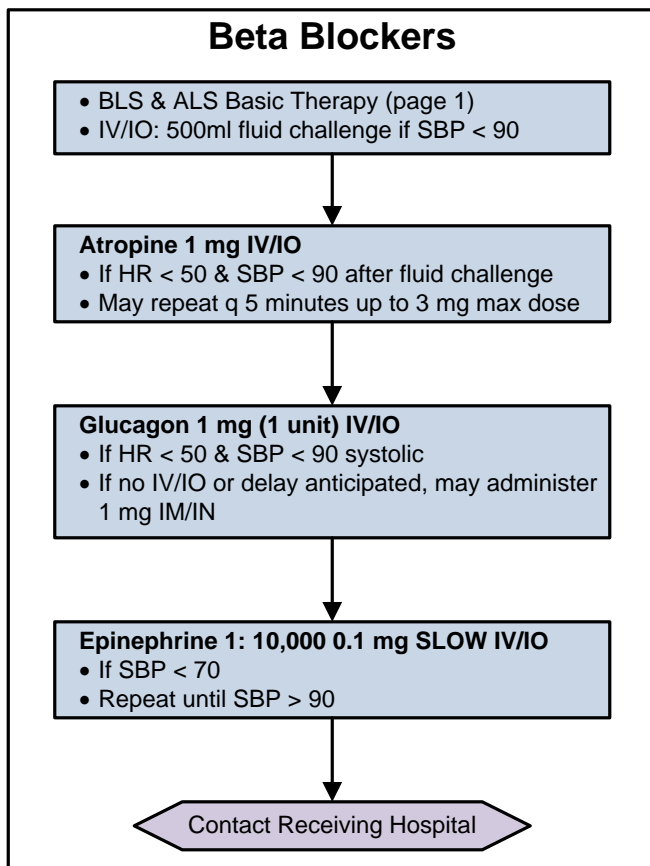
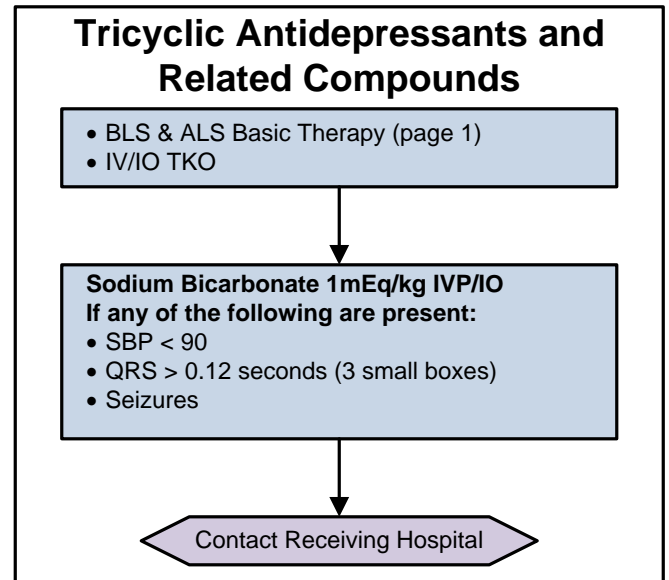
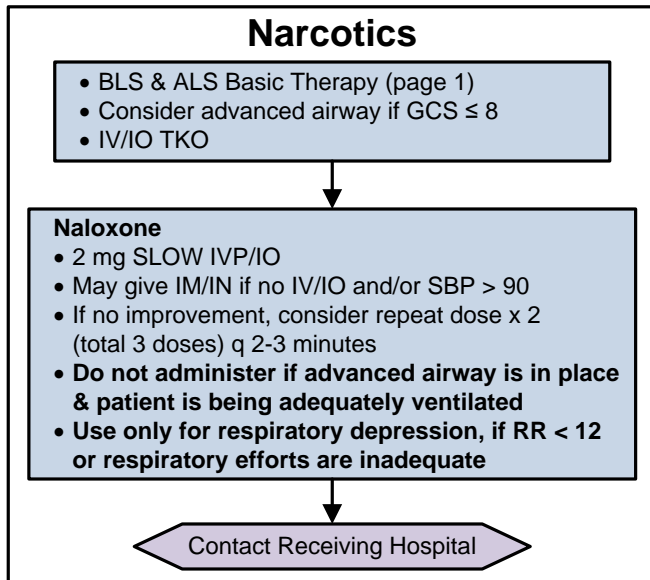
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SUBJECT: INGESTIONS AND OVERDOSES

**SPECIFIC THERAPY: INGESTIONS & OVERDOSES**





SUBJECT: INGESTIONS AND OVERDOSES

SPECIFIC THERAPY: INGESTIONS & OVERDOSES

**Organophosphate or Carbamate Pesticides**

- BLS & ALS Basic Therapy (page 1)
- IV/IO TKO

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

If exposed to pesticide externally:  
Reference Haz Mat Protocol E-7

Contact Receiving Hospital

**Hydrofluoric Acid (HF)**

- Oral ingestions require immediate treatment as Hydrofluoric Acid (HF) can cause fatal hypocalcemia
- Early signs of hypocalcemia include:
  - Tingling or “pins and needles” sensation around the mouth, lips, hands or feet
  - Hand or foot spasms
  - QT interval prolongation

- BLS & ALS Basic Therapy (page 1)
- IV/IO TKO

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

Contact Receiving Hospital

Exposed to HF externally?

Go to Haz Mat Protocol E-7

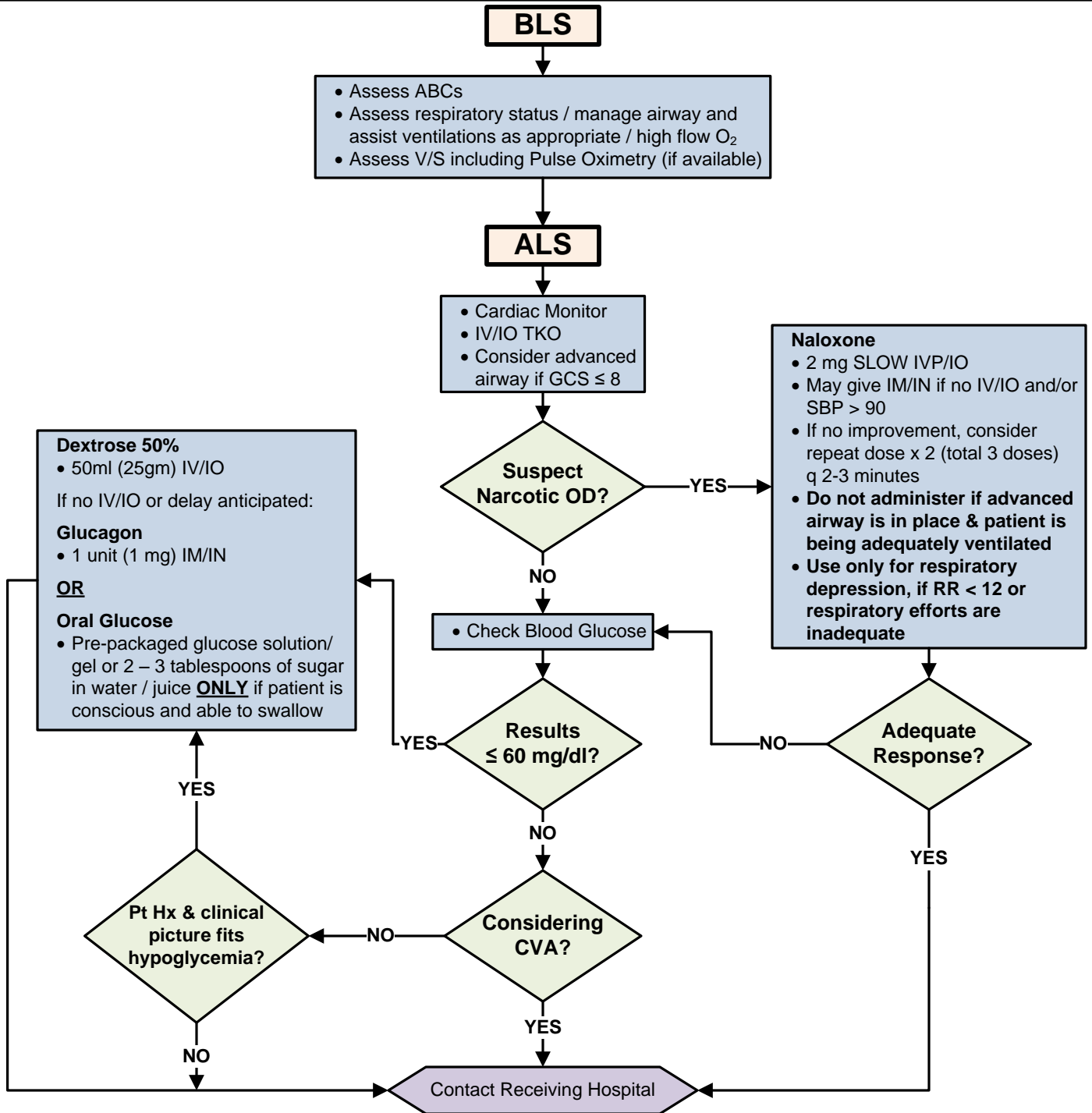
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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**NEUROLOGICAL  
REFERENCE NO. N-1**

**SUBJECT: ALTERED LEVEL OF CONSCIOUSNESS**



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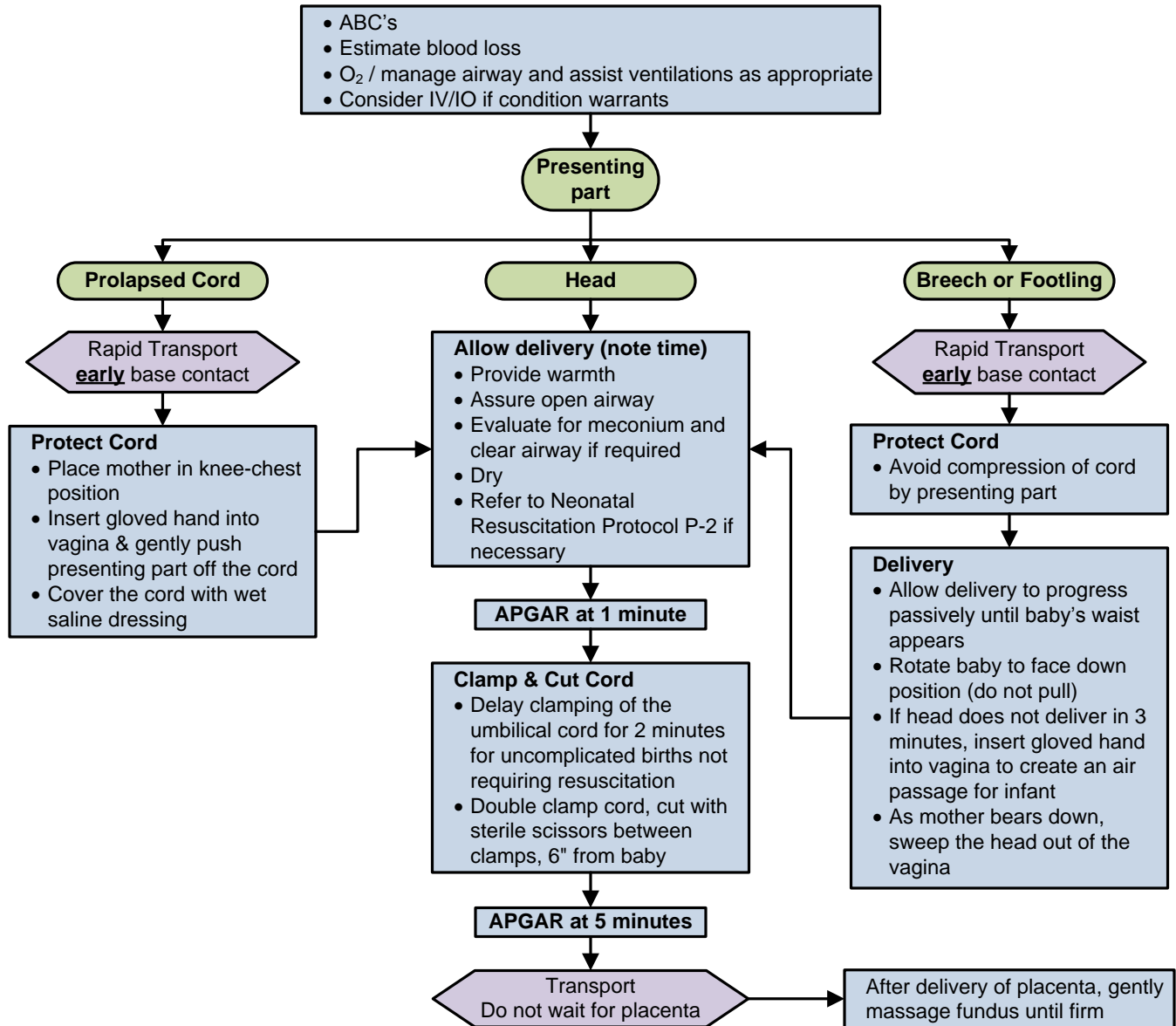
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**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**OBSTETRIC / GYN**  
**REFERENCE NO. OB / G-1**

**SUBJECT: CHILDBIRTH**



		0	1	2
<b>A</b>	Appearance	Blue / Pale	Peripheral cyanosis	Completely pink
<b>P</b>	Pulse	Absent	< 100	> 100
<b>G</b>	Grimace	Flaccid / Limp	Some flexion	Active motion
<b>A</b>	Activity	No response	Some motion / cry	Vigorous cry
<b>R</b>	Respiration	Absent	Slow / irregular	Good / Crying

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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC  
REFERENCE NO. P-3**

**SUBJECT: APPARENT LIFE THREATENING EVENT (ALTE) - ≤ 2 YEARS OLD**

- An Apparent Life-Threatening Event (ALTE) is any episode that is frightening to the observer (may think the infant or child has died) and usually involves any combination of the following symptoms:
  - Apnea (central or obstructive)
  - Color change (cyanosis, pallor, erythema, plethora)
  - Unexplained episode of choking or gagging
  - Marked change or loss in muscle tone (limpness)
- All pediatric patients ≤ 2 years old with possible ALTE shall be transported. If parent/guardian refuses medical care and/or transport, Base / Modified Base Hospital consultation is required prior to AMA release.

**BLS**

- Determine the severity, nature and duration of episode
    - Was child awake or sleeping at time of episode?
    - What resuscitative measures were taken?
  - Obtain a complete medical history to include
    - Known chronic diseases
    - Evidence of seizure activity
    - Current or recent infection
    - Recent Trauma
    - Medication history
    - Unusual sleeping or feeding patterns
    - Known gastro esophageal reflux or feeding patterns
  - Assume history given is accurate
  - Perform a comprehensive physical assessment including:
    - General appearance
    - Skin color
    - Evidence of trauma
    - Extent of interaction with the environment
- \*NOTE: Exam May Be Normal**
- Pulse Oximetry (if available)
  - Treat any identifiable causes as indicated

**ALS**

- Cardiac Monitor
- Check Blood Glucose if hypoglycemia suspected

**Results  
< 60 mg/dl?**

YES

Go to ALOC  
Protocol  
P-24

NO

• **TRANSPORT**

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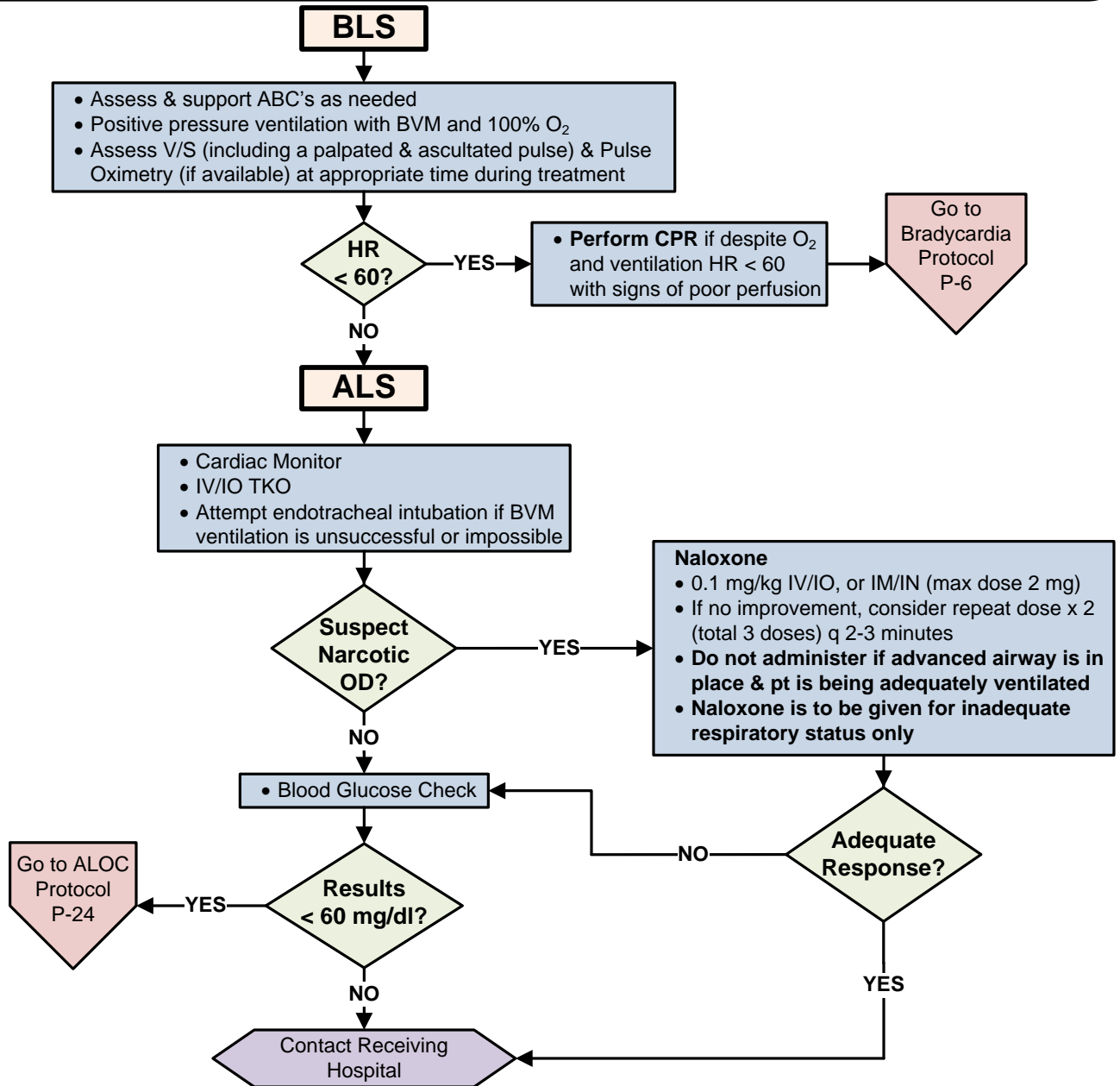
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TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC  
REFERENCE NO. P-12**

**SUBJECT: RESPIRATORY FAILURE / ARREST**

Anticipate respiratory failure & possible respiratory arrest if any of the following are present:

- Increased respiratory rate, with signs of distress (e.g. increased effort, nasal flaring, retractions, or grunting)
- An inadequate respiratory rate, effort, or chest excursion (e.g. diminished breath sounds, gasping, and cyanosis), especially if mental status is depressed
- Note: Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible



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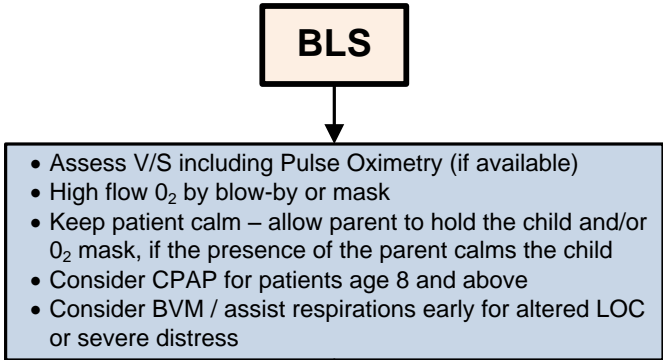


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TREATMENT PROTOCOL – MEDICAL EMERGENCY**

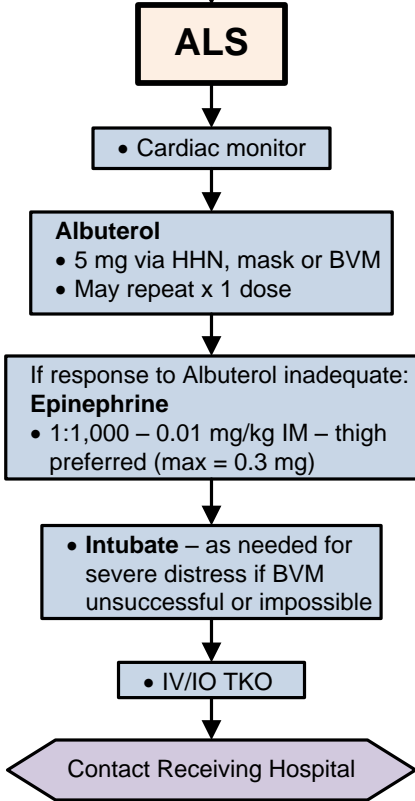
**PEDIATRIC  
REFERENCE NO. P-14**

**SUBJECT: RESPIRATORY DISTRESS – WHEEZING**

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



- SIGNS OF RESPIRATORY DISTRESS**
- MILD RESPIRATORY DISTRESS
- Mild Wheezing
  - SOB
  - Cough
- MODERATE – SEVERE RESPIRATORY DISTRESS
- Cyanosis
  - Accessory muscle use
  - Inability to speak > 2 words
  - Severe Wheezing / SOB



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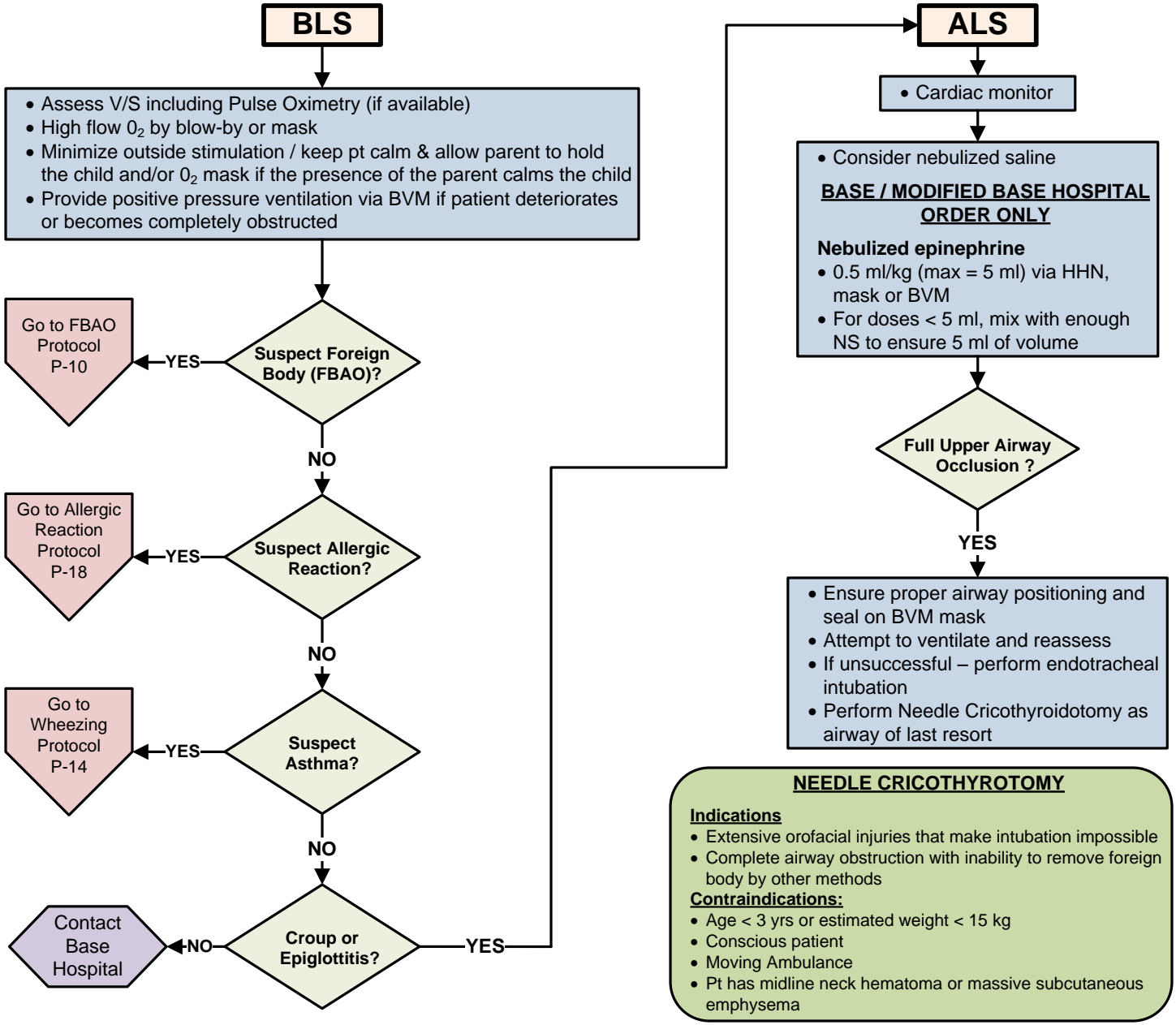


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TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC  
REFERENCE NO. P-16**

**SUBJECT: RESPIRATORY DISTRESS – STRIDOR**

- The hallmark of upper airway obstruction (i.e. croup, epiglottitis, foreign body airway obstruction) is inspiratory stridor.
- Obtain History – Foreign body aspiration, fever, drooling, sore throat, sputum production, onset, duration, medications, asthma, exposures (allergens, toxins, smoke) or trauma (blunt / penetrating).
- Do not attempt to visualize the throat or insert anything into the mouth if epiglottitis suspected.
- \*Note: Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible.



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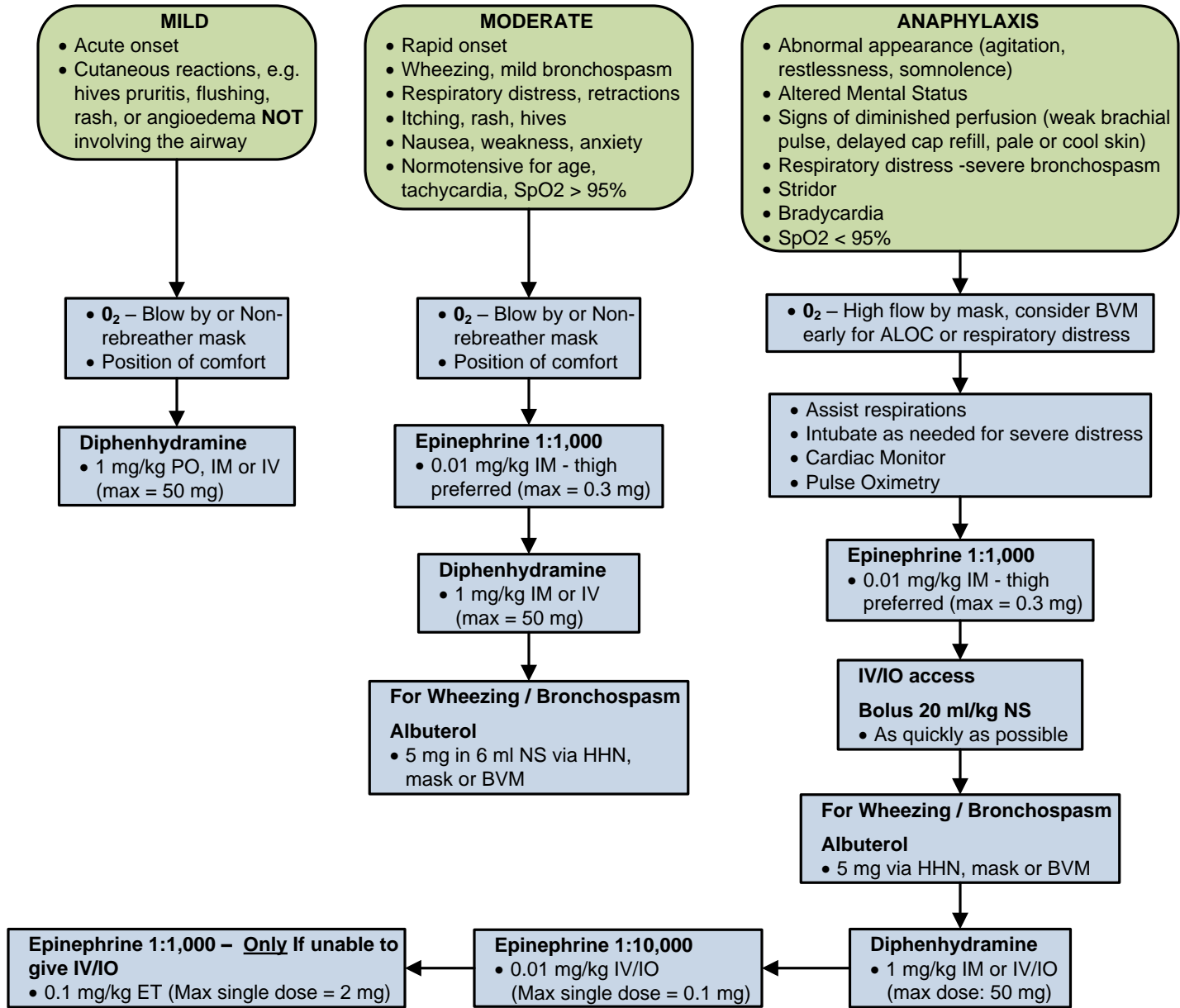


**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC**  
**REFERENCE NO. P-18**

**SUBJECT: ALLERGIC REACTION / ANAPHYLAXIS**

- If the patient is in severe distress, consider immediate transport with treatment en route
- **History** - History of exposure to allergens (bee stings, seafood, nuts, medications), prior allergic reactions, prior asthma. Medications already administered for this event including benadryl, Epi-pen, or inhalants.
- **Note:** Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible



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**SIERRA SACRAMENTO VALLEY EMS AGENCY  
TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC  
REFERENCE NO. P-20**

**SUBJECT: SHOCK**

- Shock in children may be subtle and difficult to recognize. Tachycardia may be the only sign noted. Hypotension is a late sign of shock. Determining B/P may be difficult and readings may be inaccurate in children < 3 years of age
- Obtain History Including:
  - Onset and duration of symptoms
  - Fluid Loss (vomiting, diarrhea)
  - Fever, infection, trauma or ingestion
  - History of: allergic reaction, cardiac disease or rhythm disturbances
- Important signs to watch for:

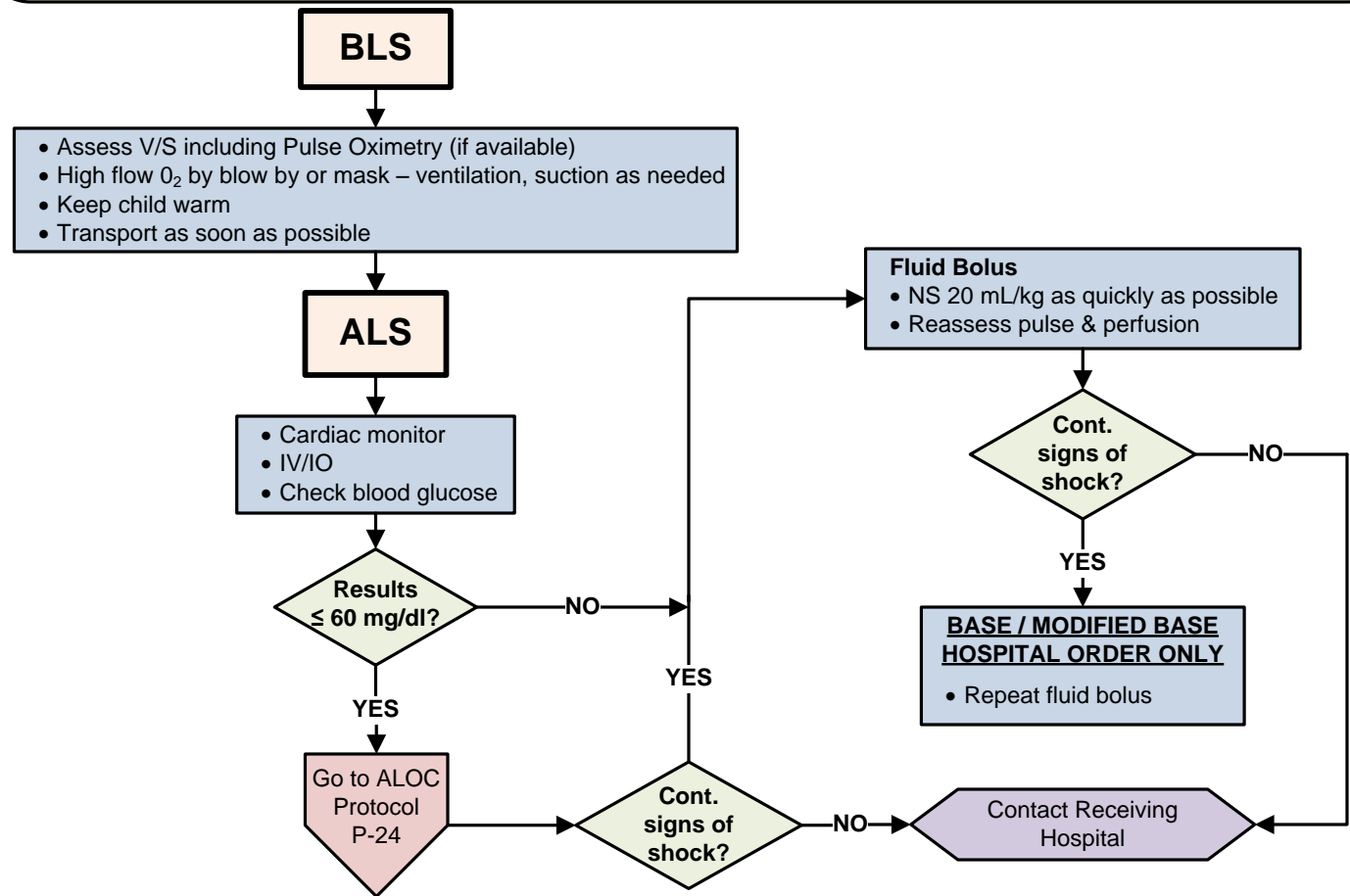
**COMPENSATED SHOCK**

- Tachycardia
- Cool extremities
- Capillary refill time > 2 seconds (despite warm ambient temperature)
- Weak peripheral pulses compared with central pulses
- Normal blood pressure

**DECOMPENSATED SHOCK**

- Hypotension and / or bradycardia (late findings)
- Decreased mental status
- Decreased urine output
- Tachypnea
- Non-detectable distal pulses with weak central pulses

• Note: Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible



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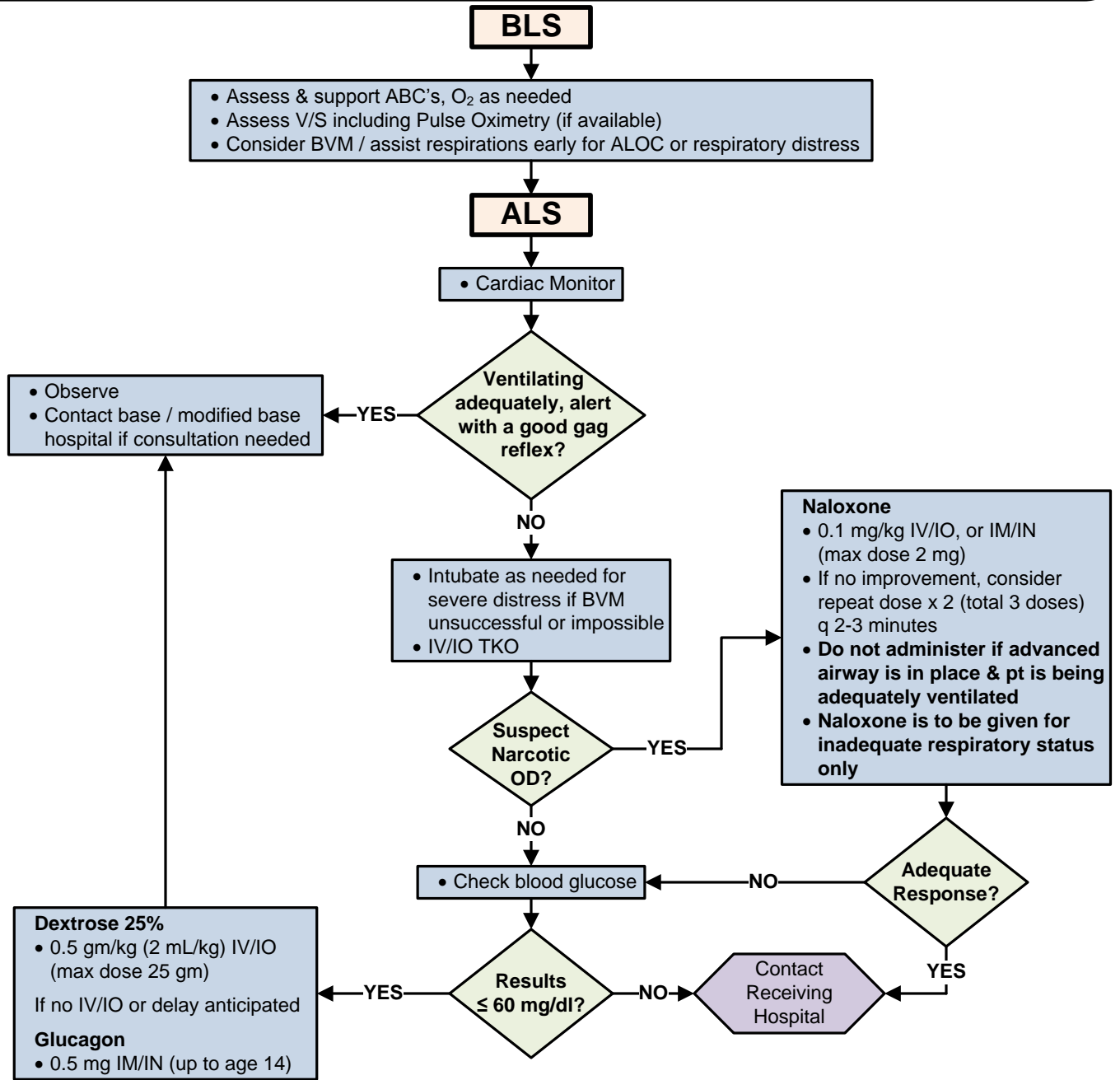


**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC**  
**REFERENCE NO. P-22**

**SUBJECT: OVERDOSE / POISONING**

- Poison Control Contact Info for Base Physicians or MICN's – Voice: 1-800-222-1222 / TTY: 1-800-972-3323
- Note: Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible
- Consult with base / modified base if blood glucose reading is > 60 mg/dl but hypoglycemia is suspected



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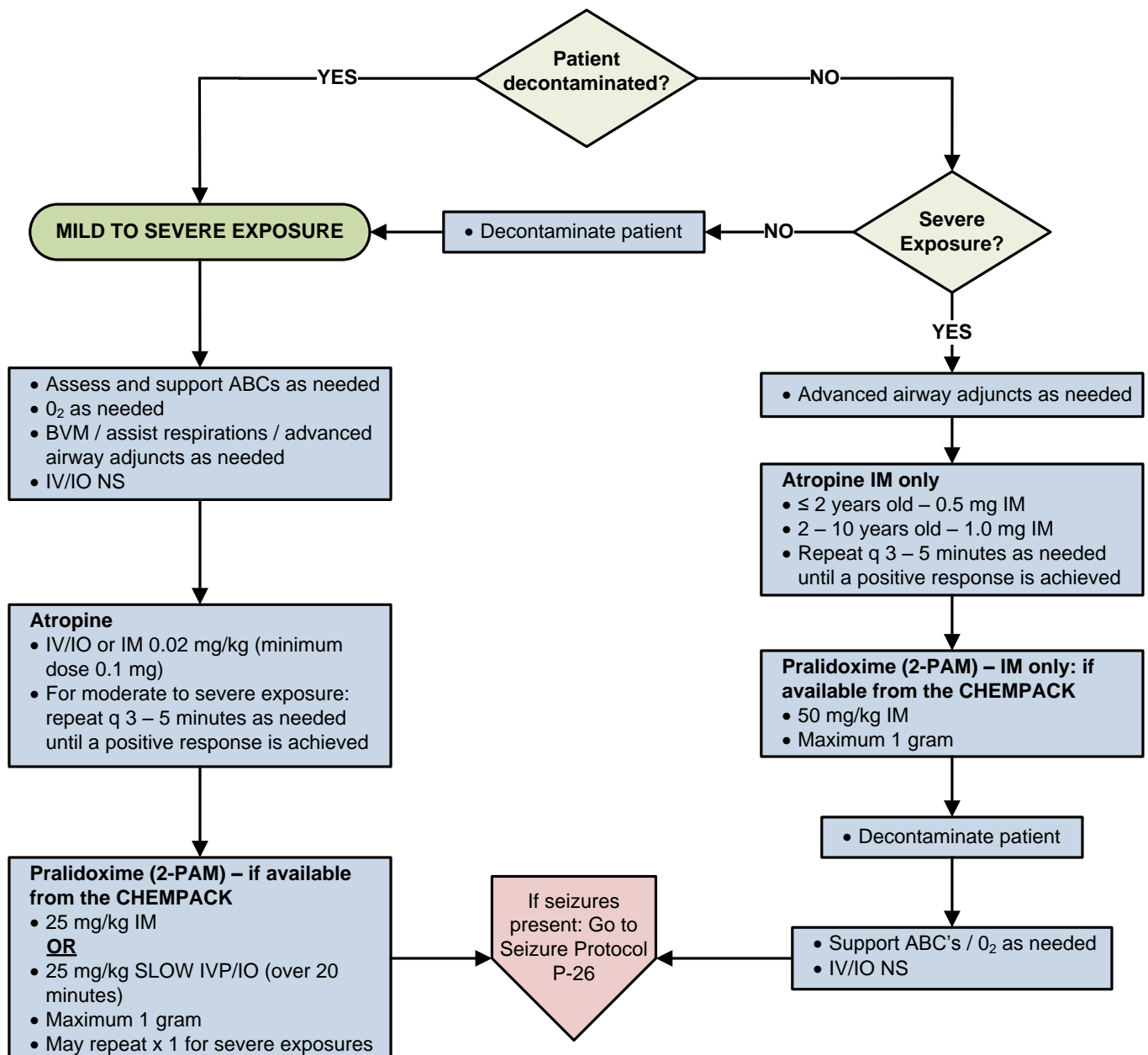
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SUBJECT: OVERDOSE / POISONING

**NERVE AGENT / ORGANOPHOSPHATE EXPOSURE**

- All providers will ensure personal safety by assuring adequate decontamination of victims and using appropriate personal protective equipment (PPE).
- Under no circumstances should responding personnel at any level use personal protective equipment (PPE) or assist in patient decontamination without completing the required training.
- Only patients with severe exposure will be treated within the Exclusion Zone (Hot Zone) or contaminated area by personnel who have specific training to allow them to function in that area.
- Patients in the Exclusion Zone (Hot Zone) with severe exposure shall be treated with IM medication only.
- Auto-injectors are NOT to be used in children < 40 kg.



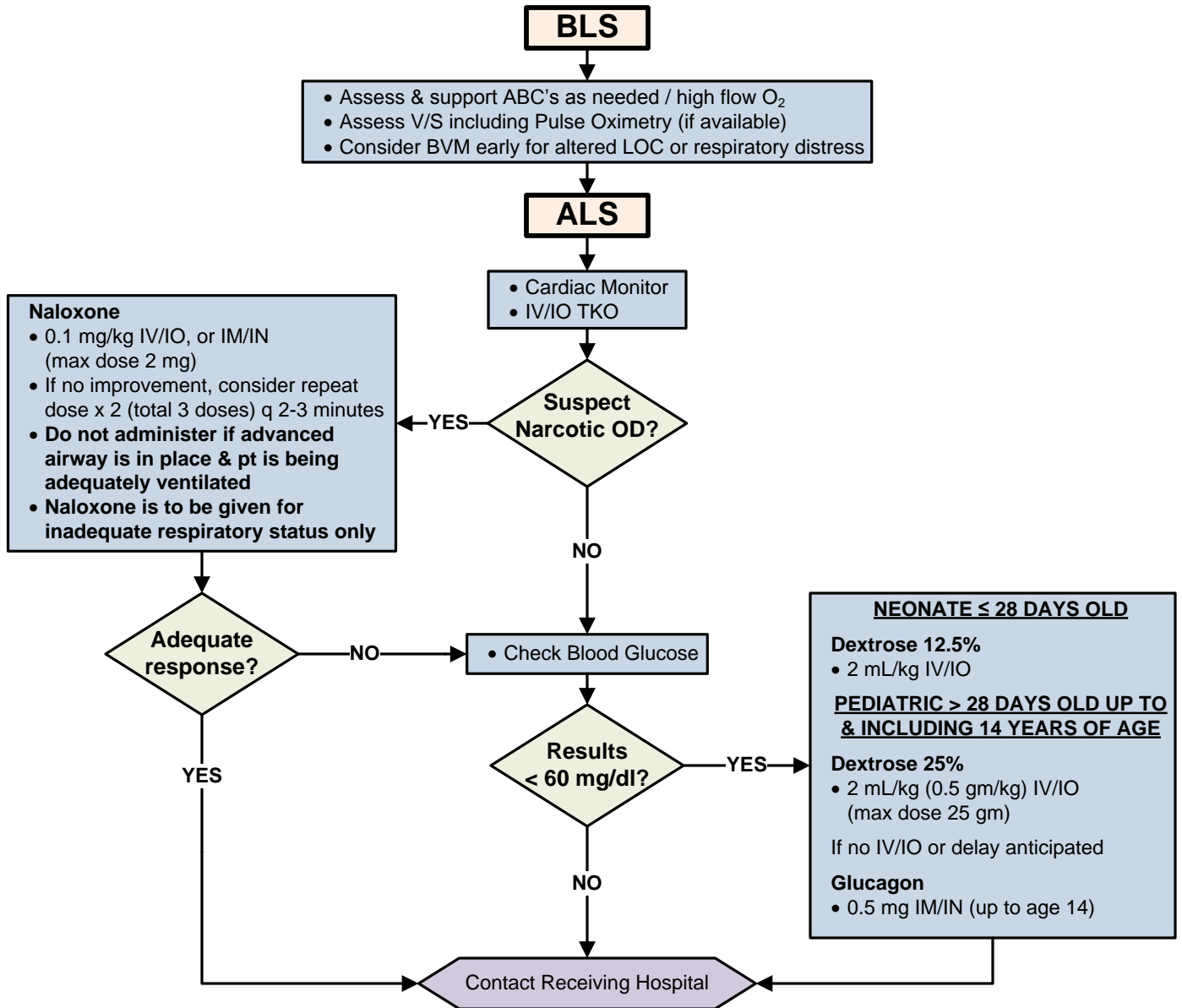


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TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC  
REFERENCE NO. P-24**

**SUBJECT: ALTERED LEVEL OF CONSCIOUSNESS**

- Clinical setting and/or medical history may dictate naloxone or dextrose as the initial medication
- Note: glucose paste or glucose solution, sugared soft drinks, orange juice or other oral glucose may be administered if the patient is: 1) able to maintain their airway; and, 2) able to follow commands
- Consult with base / modified base if blood glucose reading is > 60 mg/dl but hypoglycemia is suspected



**\* If Signs / Symptoms of ALTE: Go to ALTE Protocol P-3**

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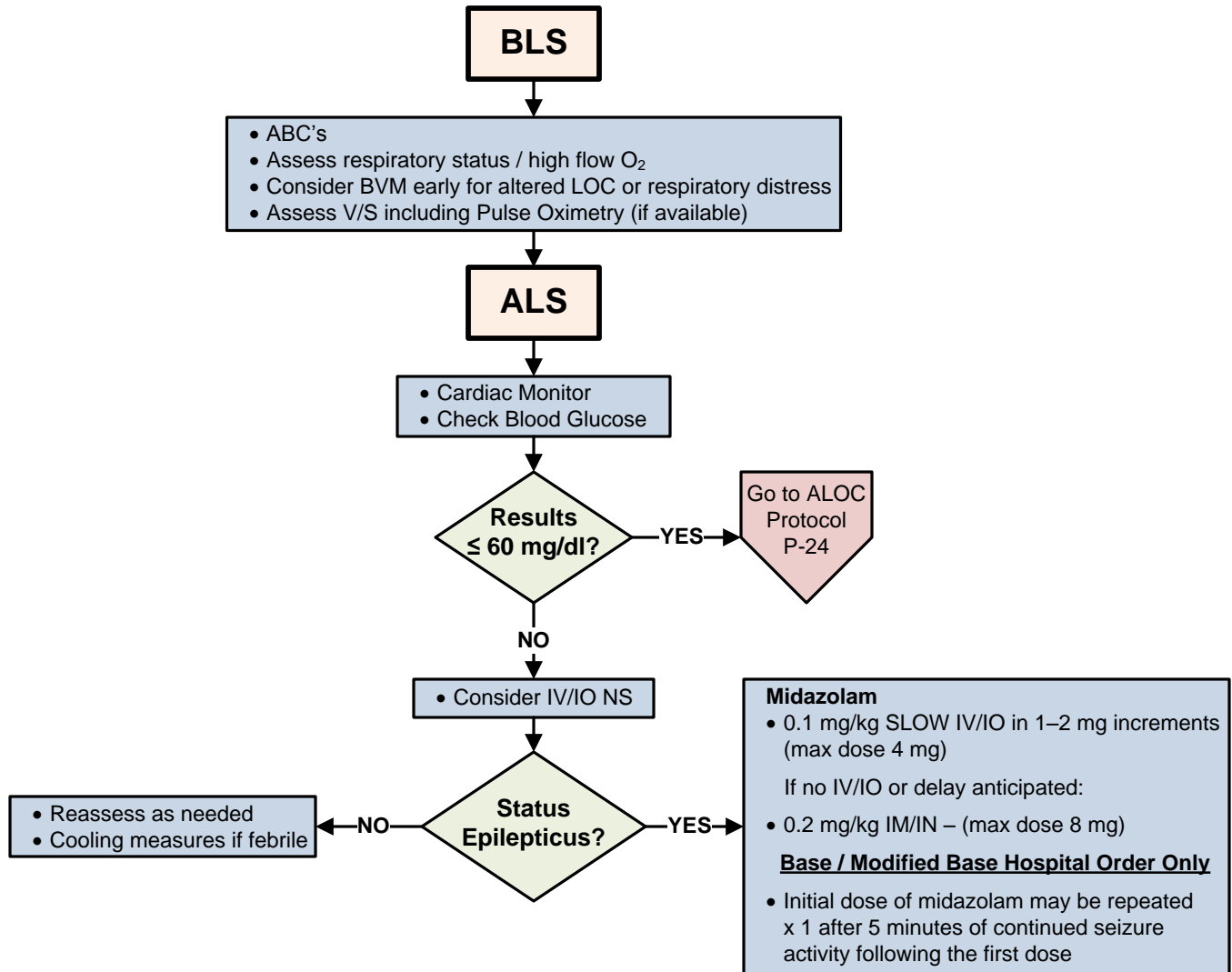


**SIERRA SACRAMENTO VALLEY EMS AGENCY**  
**TREATMENT PROTOCOL – MEDICAL EMERGENCY**

**PEDIATRIC**  
**REFERENCE NO. P-26**

**SUBJECT: SEIZURE**

- Only prolonged or continuous seizure activity or repetitive seizures require ALS intervention.
- Cooling Measures: loosen clothing and/or remove outer clothing / blankets.
- Use length based resuscitation tape to determine drug doses.
- Note: Perform endotracheal intubation only if BVM ventilation is unsuccessful or impossible.



**Status Epilepticus Definition**  
 Two (2) or more seizures without any intervening periods of consciousness, or a single seizure lasting > 5 minutes

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# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 913

## SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE

### **PURPOSE:**

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

### **AUTHORITY:**

California Health and Safety Code, Division 2.5, Sections 1797.84, 1797.185, 1797.194, 1797.214.

California Code of Regulations, Title 22, Division 9.

### **POLICY:**

- A. In order to be eligible for accreditation, an individual shall:
1. Possess a valid Paramedic License issued in the State of California.
  2. Complete an S-SV Paramedic Accreditation application.
  3. Provide written proof of current or offered employment as a paramedic with an S-SV EMS approved ALS service provider.
  4. Pay the accreditation fee.
  5. Provide a copy of California Driver's License or government issued photo identification card.
  6. Once the above steps are completed, attend an S-SV EMS approved orientation of the S-SV EMS system.
  7. Successfully complete and demonstrate competency in optional S-SV Paramedic Scope of Practice procedures/medications. Once successfully tested in any of these procedures/medications in any jurisdiction in California, no further testing shall be required if the testing agency or jurisdiction provides documentation.
  8. Successfully complete a supervised pre-accreditation field evaluation consisting of up to 10 ALS contacts.

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**SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE**

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- a. This requirement shall be waived by providing documentation of five (5) ALS contacts in the S-SV region during the paramedic education program field internship.
  - b. This requirement shall be waived if the paramedic accreditation candidate has been actively employed as a field paramedic in the State of California, within the past six (6) months, and has a minimum of one (1) year's experience as a paramedic.
9. Pass an S-SV examination on S-SV policy/procedure and protocols with a minimum score of 80%. If the examination is failed twice, the orientation shall be repeated prior to re-testing.
  10. All of the above requirements shall be met within 60 days of completion of the S-SV orientation.
  11. Upon completion of all the above requirements, the individual will be issued an S-SV Paramedic Accreditation Card with effective and expiration dates. The S-SV Paramedic Accreditation Card will have the same expiration date as the individual's current California State Paramedic license.
- B. Requirements for Maintaining S-SV Paramedic Accreditation:

To maintain continuous accreditation, a paramedic shall:

1. Complete and submit an S-SV Paramedic Accreditation application.
2. Maintain and provide proof of continuous paramedic licensure in the State of California.
3. Maintain employment as a paramedic in the S-SV region with an approved ALS service provider.
4. Maintain and provide proof of continuous PALS or PEPP recognition.

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

5. Completion of S-SV EMS Agency mandated education, as required. This education includes, but is not limited to, policies, procedures, skills, medications and/or devices/equipment.
6. The ALS service provider will provide orientation to all Paramedic personnel for all new and/or revised policies/protocols and/or procedures.
  - a. The ALS service provider shall be responsible for ensuring that all field employees are kept current on local policies and procedures. This

**SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE**

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includes part-time employees that may work shifts within the S-SV EMS region on an infrequent basis.

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

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

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

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

- 1. A lapse of less than one year:
  - a. Complete and submit an S-SV Paramedic Accreditation application.
- 2. A lapse of more than one year but less than two years:
  - a. Complete and submit an S-SV Paramedic Accreditation application.
  - b. Provide the S-SV EMS Agency with written documentation of completion of orientation/training by the employing ALS service provider to all S-SV EMS Agency protocol updates during the lapse of accreditation.
- 3. A lapse of more than two years:
  - a. All requirements for initial accreditation, as outlined in Section A of this policy, shall be met.

**D. ALS Service Provider Agency Responsibilities:**

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

**APPLICATION PROCESSING:**

- A. A completed and signed application and all required supporting documentation must be submitted to the S-SV EMS Agency prior to processing. Incomplete applications will not be processed.

**SUBJECT: PARAMEDIC ACCREDITATION TO PRACTICE**

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1. Incomplete applications will be maintained by the S-SV EMS Agency for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.
  
- B. The S-SV EMS Agency will process completed applications within 10 business days.

**CROSS REFERENCES:**

Policy and Procedure Manual

Paramedic Scope of Practice, Reference No. 803.

# SIERRA-SACRAMENTO VALLEY EMS AGENCY PROGRAM POLICY

REFERENCE NO. 915

**SUBJECT: MOBILE INTENSIVE CARE NURSE AUTHORIZATION /  
REAUTHORIZATION**

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## **PURPOSE**

To establish a mechanism for obtaining authorization/reauthorization to practice as a Mobile Intensive Care Nurse (MICN) within the S-SV EMS region.

## **AUTHORITY**

California Health and Safety Code, Division 2.5, Sections 1797.56, 1797.200, 1798.100 and 1798.200.

California Code of Regulations, Title 22, Division 9, Chapter 4.

## **POLICY**

In order to be eligible for authorization/reauthorization to practice as an MICN in the S-SV EMS region, all applicants shall:

- A. Be currently licensed as a registered nurse in the State of California.
- B. Maintain CPR and ACLS recognition.
- C. Be employed by an S-SV EMS Agency base hospital and recommended for authorization/reauthorization.
- D. Meet all authorization/reauthorization requirements listed in this policy.

### **Initial Authorization:**

Applicants shall have at least six months (1040 hours) of clinical experience within the last two years in the emergency department of an acute care hospital, and meet the criteria of one of the following categories in order to be eligible for initial S-SV EMS Agency authorization:

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**Effective Date: 06/01/2012**  
**Next Review Date: 10/2014**  
**Approved:**

**Date last Reviewed / Revised: 02/12**  
**Page 1 of 5**

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**SIGNATURE ON FILE**  
**S-SV EMS Medical Director**

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**SIGNATURE ON FILE**  
**S-SV EMS Regional Executive Director**

**SUBJECT: MOBILE INTENSIVE CARE NURSE AUTHORIZATION /  
REAUTHORIZATION**

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- A. Initial Authorization (S-SV EMS Agency approved regional course), the individual shall:
1. Have an MICN Course Completion Record from an S-SV EMS Agency approved regional MICN training program within the past 12 months.
  2. If the S-SV EMS Agency approved course was completed more than one (1) year, but less than two (2) years prior to application, the individual shall:
    - a. Attend the S-SV EMS Agency Paramedic Accreditation class within 60 days prior to the submission of the completed MICN Authorization application.
    - b. Complete four (4) hours of ambulance ride-along with an S-SV EMS Agency approved ALS service provider with two ALS contacts. This requirement shall be completed within 60 days prior to the submission of the MICN authorization application. If two ALS patient contacts are not completed, two ALS patient scenarios will be conducted by the paramedic.
- B. Initial S-SV EMS Agency Authorization (non S-SV EMS Agency regional course), the applicant shall:
1. Provide proof of completion of a basic MICN Course from another California Local Emergency Medical Services Agency (LEMSA) within the past two (2) years.
  2. Comply with the requirements listed under item two (2) in the 'Initial Authorization (S-SV EMS Agency Approved Regional Course)' section above.
  3. If the MICN course was completed over two (2) years prior to application for S-SV EMS Agency Authorization, and the individual has maintained authorization as an MICN in another California LEMSAs, they shall comply with the requirements listed under item two (2) in the 'Initial Authorization (S-SV EMS Agency Approved Regional Course)' section above. A currently valid MICN authorization card from another California LEMSAs (subject to verification) may be accepted if actual course completion documentation is not available.

**Reauthorization:**

An MICN shall fulfill the following requirements in order to maintain current S-SV EMS Agency MICN Authorization. Failure to comply means that the MICN has failed to maintain authorization and the individual shall not function as an MICN in the S-SV EMS region until the requirements are met.

**SUBJECT: MOBILE INTENSIVE CARE NURSE AUTHORIZATION /  
REAUTHORIZATION**

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A. Reauthorization without lapse in authorization:

1. Maintain license as a Registered Nurse in California.
2. Maintain CPR recognition.
3. Maintain ACLS recognition.
4. Complete a total of not less than twelve hours every two years (during each authorization period) of the following continuing education:
  - a. A minimum of four (4) hours prehospital care focused education of recorded or written patient care records, and
  - b. A minimum of four (4) hours of ambulance ride-along with an S-SV EMS Agency approved ALS service provider with two ALS contacts. If two ALS patient contacts are not completed, two ALS patient scenarios will be conducted by the paramedic.

NOTE: The remaining four (4) hours may be from either of the two above categories, at the MICN's discretion.

The MICN shall be given credit only for actual times in attendance.

5. Base hospital recommendation for reauthorization.
  - a. Each base hospital shall have a quality improvement program which includes the on-going monitoring and evaluation of MICN radio calls.
  - b. Recommendation for reauthorization shall be based on the results of the quality improvement MICN monitoring and evaluation.

B. Reauthorization after lapse in authorization:

In addition to all of the requirements specified in the 'Reauthorization without lapse in authorization' section above, an individual who's MICN Authorization has lapsed shall also meet the following requirements in order to be eligible for reauthorization:

1. If the authorization has been lapsed for a period of less than 12 months:

Complete an orientation to current S-SV policies/procedures protocols. The orientation can be provided by the S-SV base hospital coordinator or the individual may attend the S-SV EMS Agency Paramedic Accreditation class to meet this requirement.
2. If the authorization has been lapsed for a period of more than one year but less than two years:
  - a. Attend the S-SV EMS Agency Paramedic Accreditation class.
  - b. Successfully complete an S-SV base hospital MICN orientation.

**SUBJECT: MOBILE INTENSIVE CARE NURSE AUTHORIZATION /  
REAUTHORIZATION**

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- c. Complete an additional four (4) hours of ambulance ride-along with an S-SV approved ALS service provider with two (2) additional ALS contacts for a minimum total of eight (8) hours of ambulance ride along. At least four (4) hours of ambulance ride along shall be completed within 60 days prior to the submission of the MICN authorization application.
3. If the authorization has been lapsed for a period of more than two years, the initial authorization requirements must be met.

**PROCEDURE**

Eligible candidates shall complete/meet the following:

- A. Complete an S-SV EMS Agency MICN authorization/reauthorization application form.
- B. Pay the S-SV EMS Agency authorization/reauthorization fee.
- C. Provide documentation/evidence of the following:
  1. Valid and current licensure as a Registered Nurse in the State of California.
  2. Mobile Intensive Care Nurse Course Completion Record, other required documentation listed in this policy, or completion of 12 hours of required continuing education as applicable.
  3. Current CPR recognition.
  4. Current ACLS recognition.
  5. Employment in an S-SV EMS Agency base hospital emergency department, with recommendation for authorization/reauthorization.
  6. For initial authorization, proof of six months (1040 hours) of emergency department clinical experience as a registered nurse within the last two years.
- D. Successfully complete any additional applicable orientation and ride-along requirements.
- E. Provide a copy of a valid U.S. state-issued Drivers License or identification card.

**NOTE:** Upon completion of the above requirements: authorization/reauthorization will be for a period of two years from the date of completion of all S-SV EMS Agency authorization/reauthorization requests.

**SUBJECT: MOBILE INTENSIVE CARE NURSE AUTHORIZATION /  
REAUTHORIZATION**

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**APPLICATION PROCESSING**

- A. A completed and signed application and all required supporting documentation must be submitted to the S-SV EMS Agency prior to processing. Incomplete applications will not be processed.
  - 1. Incomplete applications will be maintained by the S-SV EMS Agency for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.
- B. The S-SV EMS Agency will process completed applications within 10 business days.