SIERRA-SACRAMENTO VALLEY EMERGENCY MEDICAL SERVICES AGENCY

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

DATE: October 16, 2013

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

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

SUBJECT: S-SV EMS Agency Prehospital Care Policy Manual Update #51

EFFECTIVE DATE OF IMPLEMENTATION – December 1, 2013

Enclosed is the S-SV EMS Agency Policy Manual Update #51. Please note the following regarding this update packet:

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

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

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

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

- All policies and protocols included in S-SV EMS Policy Manual Update #51 have updated on the S-SV EMS website (www.ssvems.com).

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
TOC	**Table of Contents**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
300	**Index 300**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
377	EMT Optional Skill(s) Base/Modified Base Hospital Medical Control Requirements	Replace	Updated base/modified base hospital requirements. Addition of intranasal naloxone as an EMT optional skill
400	**Index 400**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
477 & 477 A,B,C,D,E,F	EMT Optional Skill(s) Service Provider Application, Approval Process, Requirements and Responsibilities	Replace	Updated language, addition of intranasal naloxone as an EMT optional skill, and addition of annual reporting requirement and forms
505-A	S-SV EMS Ageny Hospital Capabilities	Replace	Clarification that Colusa Regional Medical Center is a Base Hospital
507	Stroke System Triage and Patient Destination	Replace	Increase of symptom onset time to 4 hours for patient diversion purposes. Updated language regarding hospital diversion
600	**Index 600**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
605	Prehospital Documentation	Replace	Updated language regarding ePCR data submission requirements (NEMSIS format). Removal of requirement to submit AED and EMT Optional Skills utilization PCR's to the base/modified base hospital
620-A	QI Tracking Form	Add	New tracking form for ROSC pilot study and paramedic optional scope of practice skills utilization
701	Prehospital Provider Agency Inventory Requirements	Replace	Updated inventory requirement, including addition of fentanyl and EMT naloxone administration supplies
702	Fireline Paramedic Inventory	Replace	Updated to be consistent with the FIRESCOPE California Fireline Paramedic ICS Position Manual (FEMP ICS 223-11) June 2013
710	Management of Controlled Substances	Replace	Addition of fentanyl
800	**Index 800**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
803	Paramedic Scope of Practice	Replace	Addition of fentanyl to the paramedic scope of practice - effective 9/1/2013
812	Base/Modified Base/Receiving Hospital Contact	Replace	Minor cleanup language, additional language regarding the requirement to contact the receiving hospital in a timely manner

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
820	Determination of Death: Public Safety, EMT, AEMT & Paramedic Personnel	Replace	Removal of language regarding base hospital contact for consistancy with updated communication failure policy and protocol C-1
835	Medical Control at the Scene of an Emergency	Replace	Minor cleanup language. Addition of "mode of transport" under the medical management at the scene
836	Hazmat	Replace	Updated definition and patient care language
839	Physician on Scene	Replace	Minor cleanup language, updated EMSA/CMA Physician on Scene Card
848	Cancellation or Reduction of ALS/LALS Response	Replace	Clarification regarding patients who meet Trauma Triage Criteria
852	Violent Patient Restraint Mechanisms	Replace	Removal of base/modified base hospital physician requirement for chemical sedation
853	Tasered Patients Care and Transport	Replace	Clarification on EMS personnel who can remove TASER probes and updated transport destination language
873	EMT Administration of Intranasal Naloxone for Suspected Narcotic Overdose With Respiratory Depression	Add	New treatment protocol for EMT optional skill administration of IN naloxone for suspected narcotic overdose with respiratory depression
877	EMT Esophageal Tracheal Airway Device (ETAD) Treatment Guidelines	Replace	Minor changes to the documentation reguirement language
890	Communication Failure	Replace	Removal of base/modified base hospital physcian order for chemical sedation, updated language regarding base/modified hospital physcian order for termination of resuscitative efforts
C-1 & C-1 (LALS)	Pulseless Arrest	Replace	Updated language regarding ALS termination of resuscitation criteria
C-5	Return of Spontaneous Circulation (ROSC)	Replace	Updated with ROSC patient destination pilot study language (effective 08/01/2013)
C-6	Tachycardia With Pulses	Replace	Addition of fentanyl administration language - effective 9/1/2013
C-7	Bradycardia	Replace	Addition of fentanyl administration language - effective 9/1/2013
C-8	Chest Pain or Suspected Symptoms of Cardiac Origin	Replace	Addition of fentanyl administration language - effective 9/1/2013
M-7	Nausea/Vomiting (From Any Cause)	Replace	Updated prophylactic zofran administration language related to the addition of fentanyl

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
N-3 & N-3 (LALS)	Suspected CVA/Stroke	Replace	Updated O_2 administration language. Increase of symptom onset time to 4 hours for patient diversion purposes. Additional 12-lead language
E-3	Frostbite	Replace	Addition of fentanyl administration language - effective 9/1/2013
E-4 & E-4 (LALS)	Bites and Envenomations	Add	New treatment protocol for bites and envenomations
E-7	Hazardous Material Exposure	Replace	Updated morphine administration language for consistency with other protocols. Addition of fentanyl administration language
E-7 (LALS)	Hazardous Material Exposure	Replace	Updated morphine administration language for consistency with other protocols
T-6	Isolated Extremity Injury - Including Hip or Shoulder Injuries	Replace	Addition of fentanyl administration language - effective 9/1/2013
T-8 & T-8 (LALS)	Hemorrhage	Replace	Updated list of approved hemostatic dressings
T-10	Burns: Thermal & Electrical	Replace	Addition of fentanyl administration language - effective 9/1/2013
P-28	Burns: Thermal & Electrical (Pediatric)	Replace	Addition of fentanyl administration language - effective 9/1/2013
P-30	Isolated Extremity Injury - Including Hip or Shoulder Injuries (Pediatric)	Replace	Addition of fentanyl administration language - effective 9/1/2013
P-32	Nausea/Vomiting (From Any Cause) - Pediatric	Replace	Updated prophylactic zofran administration language related to the addition of fentanyl
900	**Index 900**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
977	EMT Optional Skill(s) Personnel Requirements for Accreditation	Add	Updated accreditation language, addition of intranasal naloxone as an EMT optional skill
1100	**Index 1100**	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes
1102	King Airway	Replace	Routine review, minor language clean up only, no material changes
1103	Mucosal Atomization Device	Replace	Addition of fentanyl, calrification regaring IN naloxone administration for approved EMT Optional Skill(s) personnel
1104	Advanced Airway Management	Replace	Additional language regarding nasotracheal and pediatric intubation QI reporting and tracking. Additional chemical sedation dosing

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

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SIERRA-SACRAMENTO VALLEY EMS AGENCY

BASE/MODIFIED BASE HOSPITAL
SECTION III

SUBJECT: INDEX **REFERENCE NO. 300**

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 377

SUBJECT: EMT OPTIONAL SKILL(S) BASE/MODIFIED BASE HOSPITAL MEDICAL CONTROL REQUIREMENTS

PURPOSE:

To establish the requirements for base/modified base hospital medical control of EMT optional skill(s) accredited personnel. The EMT optional skills available in the S-SV EMS region are:

A. Utilization of perilaryngeal airway adjuncts:

1. Esophageal-tracheal airway device (ETAD)

2. King LT airway device

B. Administration of intranasal naloxone for suspected narcotic overdose with respiratory depression.

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

D. Administration of atropine and pralidoxime chloride by auto-injector (Mark-I/DuoDote Kit) for nerve agent exposure.

AUTHORITY:

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

California Code of Regulations, Title 22, Chapter 2, Section 100064

PROCEDURE:

Medical Control:

The base/modified base hospital shall provide medical control for S-SV EMS Agency EMT optional skill(s) accredited personnel. This shall include the following:

A. Appointment of a physician medical director. A registered nurse and/or paramedic may assist the medical director with responsibilities of monitoring the EMT optional skill(s).

B. Provide assistance with periodic training, skill(s) proficiency demonstrations, organized field care audits, structured clinical experience and continuous quality improvement in compliance with S-SV EMS Agency policies as necessary.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Optional Skill(s) Provider Application, Approval Process, Requirements, and Responsibilities, Reference No. 477

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

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

EMT Administration of Intranasal Naloxone for Suspected Narcotic Overdose With Respiratory Depression, Reference No. 873

EMT Esophageal Tracheal Airway Device Treatment Guidelines, Reference No. 877

Nerve Agent Treatment, Reference No. E-8

EMT Optional Skill(s) Personnel Requirements for Accreditation, Reference No. 977

King Airway, Reference No. 1102

Advanced Airway Management, Reference No. 1104

SIERRA-SACRAMENTO VALLEY EMS AGENCY

PROVIDER AGENCIES
SECTION IV

SUBJECT: INDEX **REFERENCE NO. 400**

SUBJECT: INDEX REFERENCE NO. 400

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 477

SUBJECT: EMT OPTIONAL SKILL(S) SERVICE PROVIDER APPLICATION, APPROVAL PROCESS, REQUIREMENTS AND RESPONSIBILITIES

PURPOSE:

A. To establish the application and approval process for utilization of EMT optional skill(s) by prehospital provider agencies in the S-SV EMS region.

B. To establish the requirements and responsibilities of S-SV EMS Agency approved EMT optional skill(s) service providers.

C. The EMT optional skills available in the S-SV EMS region are:

1. Utilization of perilaryngeal airway adjuncts:

   a. Esophageal-tracheal airway device (ETAD)

   b. King LT Airway device

2. Administration of intranasal naloxone for suspected narcotic overdose with respiratory depression.

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

4. Administration of atropine and pralidoxime chloride by auto-injector (Mark-I/DuoDote Kit) for nerve agent exposure.

AUTHORITY:

California Health & Safety Code, Division 2.5, Section 1797.80, 1797.90, 1797.170, 1797.177, 1797.220, 1798.2 and 1798.104

California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100064

POLICY:

Any provider wanting to utilize one or more of the EMT optional skills shall be approved as an EMT optional skill(s) service provider by the S-SV EMS Agency.

An EMT optional skill(s) service provider shall meet all requirements set forth by State law, regulations and S-SV EMS Agency policies.

I. APPROVAL PROCESS

A. EMT Optional Skill(s) Program Application and Approval Requirements:

1. Any provider wanting to utilize one or more of the EMT optional skills shall submit an S-SV EMT Optional Skill(s) Service Provider Application packet to the S-SV EMS Agency.

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

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

   a. EMT optional skill(s) being applied for.

   b. A letter of intent to provide the EMT optional skill(s) being applied for from the Chief Administrative Officer (CAO) expressing willingness to abide by all S-SV EMS Agency policies, procedures and EMT optional skill(s) program requirements.

   c. A description of the geographic area within which the optional skill(s) will be utilized (Include response area size, population, population distribution and any other unique characteristics associated with the area that may impact the program, such as; tourist impact, recreational activities, large number of elderly patients, etc.).

   d. A description of the need for use of the EMT optional skill(s) within the applicant agency's service area, including the number of medical/trauma responses that may have benefited from the optional skill(s) for the last year.

   e. A letter from an S-SV EMS Agency designated base/modified base hospital documenting participation in the EMT optional skill(s) program. The names of the base hospital EMT optional skill(s) program medical director and registered nurse/paramedic coordinator shall be included.

   f. A written service provider Continuous Quality Improvement (CQI) Program, including name(s) of personnel responsible for the program.

   g. A completed S-SV EMS Agency Optional Skill(s) Service Provider Principal Instructor Form. The principal instructor shall be a

physician, registered nurse, physician assistant, paramedic or Advanced EMT, licensed or certified in California or a physician licensed in another state immediately adjacent to the S-SV EMS Region.

h. An outline or description of the applicant agency's plans for the provision of organized training sessions and/or structured clinical experience for accredited EMT optional skill(s) personnel.

i. The applicant agency's procedure for collection, disposition and retention of all pertinent medical records.

B. S-SV EMS Agency EMT Optional Skill(s) Program Approval Process:

1. The S-SV EMS Agency shall notify the EMT optional skill(s) applicant agency within seven (7) working days of receiving the request that:

a. The application has been received;

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

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

2. Program approval or disapproval shall be made in writing, to the applicant agency within a reasonable period of time, after receipt of all required documentation. This time period shall not exceed thirty (30) calendar days.

II. APPROVED EMT OPTIONAL SKILL(S) SERVICE PROVIDER AGENCY REQUIREMENTS AND RESPONSIBILITIES

A. EMT Optional Skill(s) Program Training Requirements:

1. Only individuals working for an S-SV EMS Agency approved EMT optional skill(s) service provider shall be eligible for EMT optional skill(s) training or accreditation.

2. EMT optional skill(s) service provider agencies shall:

a. Utilize the EMT optional skill(s) training program approved or provided by the S-SV EMS Agency, including the final written and skills examinations.

b. Provide for initial training in the EMT optional skill(s). The minimum required training time requirements are as follows:

- ETAD/King Airway Device - a minimum of five (5) hours
- Intranasal naloxone – a minimum of two (2) hours
- Auto-injector epinephrine – a minimum of two (2) hours
- Mark I/DuoDote Kit – a minimum of two (2) hours

c. Provide all training equipment necessary to ensure a sound EMT optional skill(s) training program (i.e., manikins, audiovisual aids, training auto-injectors, etc.).

d. Utilize only instructors qualified by education or experience to teach the required curriculum. The instructor shall be a physician, registered nurse, physician assistant, paramedic or Advanced EMT, licensed or certified in California or a physician licensed in another state immediately adjacent S-SV EMS Region.

e. An EMT accredited in the optional skill(s) may assist in the demonstration of competency and training of the approved optional skill(s).

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

g. Abide by the accreditation process as outlined in S-SV EMS Agency 'EMT Optional Skill(s) Personnel Requirements for Accreditation' policy, Reference No. 977.

h. Provide for the EMT optional skill(s) personnel training and skill(s) maintenance requirements, on an ongoing basis. Each individual accredited in EMT optional skill(s) shall demonstrate optional skill(s) competency every six (6) months after initial accreditation.

NOTE: If the organized training session(s) are provided by an EMT optional skill(s) service provider that is not an approved CE provider, the EMT optional skill(s) service provider shall be responsible for maintaining the following documentation associated with the training:

- Session title
- Session objectives
- Session outline
- Attendance roster that includes; topic/title, date, time and instructor signature
- Instructor qualifications: Instructors shall be a physician, registered nurse, physician assistant, paramedic or Advanced EMT, licensed or certified in California or a physician licensed in another state immediately adjacent S-SV EMS Region. An EMT accredited in the optional skill(s) may assist in the demonstration of competency and training of the approved optional skill(s).

B. Records/Data Collection:

1. A Patient Care Report (PCR) shall be completed for each patient on whom the optional skill is utilized. EMT optional skill(s) personnel shall be responsible for providing clear, concise, complete and accurate documentation on the PCR.

2. The provider agency shall develop procedures for collection, disposition, and retention of all pertinent medical records in accordance with S-SV EMS Agency Prehospital Documentation policy, Reference No. 605.

3. The following forms shall be completed and submitted to the S-SV EMS Agency on an annual basis for the previous calendar year (no later than January 31st):

   a. EMT Optional Skills Service Provider Competency Documentation Record (Reference No. 477-D)

   b. EMT Optional Skill(s) Service Provider Annual Program Update Form (Reference No. 477–E)

   c. EMT Optional Skill(s) Service Provider Annual Utilization Report Form (Reference No. 477-F)

C. EMT Optional Skill(s) Continuous Quality Improvement (CQI) Program Requirements:

EMT optional skill(s) service providers shall have sufficient staff to assure:

1. Timely and competent review of all EMT optional skill(s) managed cases.

2. Accurate documentation of required data.

3. Compliance to S-SV EMS Agency policies and treatment protocols.

4. Analysis of system performance.

D. Other Program Requirements:

1. EMT optional skill(s) service providers shall notify the S-SV EMS Agency, in writing, of the following:

   a. Names of individuals who have failed to maintain accreditation requirements.

b. Names of accredited individuals no longer affiliated with the service provider agency.

c. Change in program instructor designation. All new instructors shall meet/complete all program instructor requirements prior to providing course instruction.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Optional Skill(s) Base/Modified Base Hospital Medical Control Requirements, Reference No. 377

EMT Optional Skill(S) Service Provider Application Form, Reference No. 477-A

EMT Optional Skill(s) Service Provider Principal Instructor Form, Reference No. 477-B

Optional Skill(s) Accredited EMT Status Report Form, Reference No. 477-C

EMT Optional Skill(s) Service Provider Competency Documentation Record, Reference No. 477-D

EMT Optional Skill(s) Service Provider Annual Program Update Form, Reference No. 477-E

EMT Optional Skill(s) Service Provider Annual Utilization Report Form, Reference No. 477-F

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

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

EMT Administration of Intranasal Naloxone for Suspected Narcotic Overdose with Respiratory Depression, Reference No. 873

EMT Esophageal Tracheal Airway Device Treatment Guidelines, Reference No. 877

Nerve Agent Treatment, Reference No. E-8

EMT Optional Skill(s) Personnel Requirements for Accreditation, Reference No. 977

King Airway, Reference No. 1102

Advanced Airway Management, Reference No. 1104

EMT Optional Skill(s) Service Provider Application Form (477-A)

Submit completed application and supporting documentation to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Applicant Agency Information:

Agency:	Contact Person:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:

EMT optional skill(s) being applied for:

- ☐ Esophageal-tracheal airway device (ETAD) – Combitube[tm]
- ☐ King LT airway device
- ☐ Administration of intranasal naloxone for suspected narcotic overdose with respiratory depression
- ☐ Administration of epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma
- ☐ Administration of atropine/pralidoxime chloride by auto injector (Mark-1/DuoDote) for nerve agent exposure

Application Checklist

DESCRIPTION	ENCLOSED	APPROVED
Letter of intent to provide EMT optional skill(s) from the Chief Administrative Officer		
Description of the geographical area where the EMT optional skill(s) will be utilized		
Description of the need for use of the EMT optional skill(s)		
Participation letter from an S-SV EMS Agency authorized base/modified base hospital		
CQI program to include how the use of EMT optional skill(s) will be monitored		
EMT Optional Skill(s) Service Provider Principal Instructor Form (Reference No. 477-B)		
Proposed training program (if not utilizing S-SV EMS Agency provided training materials)		
Medical records collection, disposition and retention policy/procedure		

S-SV EMS Agency Approval

Name/Title	Signature	Date Approved
_____	_____	_____

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EMT Optional Skill(s) Service Provider
Principal Instructor Form (477-B)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Agency Information:

EMT Optional Skill(s) Service Provider Agency:		
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:

Principal Instructor Information:

Name of Principal Instructor:		
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:
Occupation:	Present Employer:	

I certify that I meet the following EMT optional skill(s) provider principal instructor requirements ***(attach resume)***:

☐ Qualified by education or experience to teach the required curriculum

☐ A physician, registered nurse, physician assistant, paramedic, or Advanced EMT, licensed or certified in California or a physician licensed in another state immediately adjacent to the S-SV EMS Region

_____	_____	_____
Name	Signature	Date

Service Provider Agency and Base/Modified Base Hospital Principal Instructor Approval:

EMT Optional Skill(s) Service Provider Agency Chief Administrative Officer Principal Instructor Approval

_____	_____	_____
Name/Title	Signature	Date

EMT Optional Skill(s) Provider Base/Modified Base Hospital Principal Instructor Approval

_____	_____	_____
Name/Title	Signature	Date

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Optional Skill(s) Accredited EMT Status Report Form (477-C)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Agency Information:

EMT Optional Skill(s) Service Provider Agency:
Name and Title of Person Completing this Form:
_____ _____ Signature Date:

EMT Information:

EMT Name:
EMT Certification Number:
Reason for status report (check all that apply): ☐ Is no longer affiliated as an EMT with our agency ☐ Has failed to maintain EMT Certification ☐ Has Failed to maintain CPR Certification ☐ Has failed to maintain esophageal-tracheal airway device (ETAD) – Combitube^{tm} skills proficiency ☐ Has failed to maintain King LT airway device skills proficiency ☐ Has failed to maintain intranasal naloxone skills proficiency ☐ Has failed to maintain epinephrine auto-injector skills proficiency ☐ Has failed to maintain atropine/pralidoxime chloride auto injector (Mark-I/DuoDote) skills proficiency

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EMT Optional Skill(s) Service Provider
Competency Documentation Record (477-D)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Agency Information:

EMT Optional Skill(s) Service Provider Agency:	
Calendar Year:	
Instructor's Name:	Instructor's Initials:
Instructor's Name:	Instructor's Initials:

Skills Competency Verification (Check all that apply)

☐ ETAD (Combitube™) ☐ King Airway ☐ Intranasal Naloxone

☐ Auto-Injector Epinephrine ☐ Auto-Injector Atropine/Pralidoxime Chloride (Mark 1/DuoDote)

Skills Competency Documentation (continued on second page):

EMT Name	EMT Certification #	Skill(s) Check Date	Instructor's Initials	Skill(s) Check Date	Instructor's Initials

EMT Optional Skill(s) Service Provider
Competency Documentation Record (477-D)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Skills Competency Documentation (continued):

EMT Name	EMT Certification #	Skill(s) Check Date	Instructor's Initials	Skill(s) Check Date	Instructor's Initials

EMT Optional Skill(s) Service Provider
Annual Program Update Form (477-E)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Agency Information:

Calendar Year:	Date Form Submitted:	
Agency:	Contact Person:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:
Base/Modified Base Hospital:		
EMT Optional Skills(s) Principal Instructor:		

Approved EMT optional skill(s) being utilized:

- ☐ Esophageal-tracheal airway device (ETAD) – Combitube^{tm}
- ☐ King LT airway device
- ☐ Administration of intranasal naloxone for suspected narcotic overdose with respiratory depression
- ☐ Administration of epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma
- ☐ Administration of atropine/pralidoxime chloride by auto injector (Mark-1/DuoDote) for nerve agent exposure

EMT Optional Skill(s) Accredited Personnel Information (continued on second page):

EMT Name	EMT Certification #	EMT Certification Expiration Date	CPR Certification Expiration Date

EMT Optional Skill(s) Service Provider
Annual Program Update Form (477-E)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

EMT Optional Skill(s) Accredited Personnel Information (continued):

EMT Name	EMT Certification #	EMT Certification Expiration Date	CPR Certification Expiration Date

EMT Optional Skill(s) Service Provider Annual Utilization Report Form (477-F)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

Agency Information:

Calendar Year:	Agency:	Contact Person:

EMT Optional Skill(s) Utilization Information (continued on second page):

Date	Incident #	EMT Optional Skill Utilized	Successful (Yes/No)	Complications: (please provide a brief description)

EMT Optional Skill(s) Service Provider Annual Utilization Report Form (477-F)

Submit completed forms to: John Poland, QI & Education Coordinator
Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1730, or Email – John.Poland@ssvems.com

EMT Optional Skill(s) Utilization Information (continued):

Date	Incident #	EMT Optional Skill Utilized	Successful (Yes/No)	Complications: (please provide a brief description)

SIERRA SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

Updated 12-2013

S-SV EMS AGENCY HOSPITAL CAPABILITIES

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	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 Rosevile 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				X
Mercy San Juan Medical Center	Sacramento	Receiving	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
Fremont Medical Center - L&D	Sutter	L & D Only				X				

SIERRA SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

Updated 12-2013

S-SV EMS AGENCY HOSPITAL CAPABILITIES

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
St. Elizabeth Community Hospital	Tehama	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 Rosevile Medical Center	Western Slope of Placer County
Tahoe Forest Hospital	Tahoe Basin and Eastern Slope of Nevada and Placer Counties
Mercy Medical Center Redding	Shasta County/Siskiyou County/Tehama County

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 507

SUBJECT: STROKE SYSTEM TRIAGE AND PATIENT DESTINATION

PURPOSE:

The purpose of this policy is to describe the Sierra Sacramento Valley EMS (S-SV EMS) regional stroke system. This system is designed to provide timely, appropriate care to patients who have suffered symptoms of a stroke within 4 hours of onset of symptoms or time last seen normal. Acute Stroke Patients shall be transported to a stroke receiving center in accordance with S-SV EMS Agency policies and protocols.

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

DEFINITIONS:

A. **Acute Stroke Patient** – A patient who meets assessment criteria for an acute stroke in accordance with S-SV EMS Agency treatment protocols and whose onset of symptoms or time last seen normal is 4 hours or less.

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

POLICY:

A. Identification and Destination of the Acute Stroke Patient:

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

2. Patients identified by prehospital personnel as having the onset of stroke symptoms or time last seen normal within the past 4 hours shall be transported to a stroke receiving center if transport time is less than 30 minutes.

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3. If there is any question as to the status of a patient within the 30 minute catchment area of a stroke receiving center with symptoms of a stroke, prehospital personnel shall consult with the ED physician at the closest stroke receiving center as early as possible in the patient's evaluation.

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

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

B. Notification of the Stroke Receiving Center:

As soon as feasible, preferably from the scene, prehospital personnel shall contact the intended stroke receiving center and inform them that a stroke patient is en route to that facility. It is recommended that the report be started with the statement that this is a "Stroke Alert". The prehospital report shall include at a minimum:

1. The nature of the symptoms

2. The time of onset of symptoms or when patient was last seen normal

3. The blood glucose

4. Vital signs

5. Treatment provided

C. Diversion by a Stroke Receiving Center:

Diversion of stroke patients shall only occur during times of an incapacitating internal disaster or when the CT scanner is otherwise unavailable.

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

   a. Stroke receiving center emergency department - to include a status posting on the regional electronic hospital alerting and assessment system (e.g. EMResource^{tm}) indicating that the CT scanner is unavailable

   b. Appropriate adjacent stroke receiving center(s)

   c. Appropriate prehospital provider agencies

2. All entities listed in this section shall also be notified as soon as possible in the case of an unplanned event causing the CT scanner to be unavailable as well as when the CT scanner is subsequently available.

D. Stroke Receiving Center Data Reporting, Continuous Quality Improvement Program, and Performance Standards:

S-SV EMS Agency designated stroke receiving centers shall comply with all data reporting, continuous quality improvement and performance standards as defined in individual stroke receiving center MOU's. These requirements will be the same for each stroke receiving center.

E. Prehospital Documentation:

The minimum patient care documentation indicated in the S-SV EMS Agency 'Prehospital Documentation' policy (Reference No. 605) shall be left at the stroke receiving center for all stroke patients before prehospital personnel leave the receiving hospital.

F. Notification:

The S-SV EMS Agency shall be notified no later than the end of the next business day if any of the following occur:

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

2. Any instance of diversion of a stroke patient by a stroke receiving center other than the approved instances of diversion indicated in this policy.

3. An EMS field provider fails to leave the minimum required patient care documentation at the receiving facility at the time of initial patient transport.

G. Transferring an Acute Stroke Patient to a Higher Level of Stroke Care:

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

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

2. Request an ALS ambulance utilizing the 911 system to transport the patient to a stroke receiving center, unless there is an equivalent agreement for emergent transport in place with another S-SV EMS Agency approved provider. If patient care has been initiated that exceeds the prehospital provider's scope of practice, qualified medical or nursing staff will accompany the patient in the

ambulance, or a Critical Care Transport unit may be utilized if their response time is appropriate.

3. Provide the ambulance personnel with a complete patient report and all appropriate documentation including a CT scan. Do not delay transport of the patient if complete documentation is not available. If complete documentation is not sent with the ambulance, the sending hospital will fax/electronically transmit the report to the stroke receiving center in sufficient time that it should arrive prior to the patient.

CROSS REFERENCES:

Prehospital Care Policy Manual

Patient Destination, Reference No. 505

Patient Care Documentation, Reference No. 605

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

Suspected CVA/Stroke, Reference No. N-3

SIERRA-SACRAMENTO VALLEY EMS AGENCY

DOCUMENTATION/QUALITY IMPROVEMENT
SECTION VI

SUBJECT: INDEX **REFERENCE NO. 600**

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 605

SUBJECT: PREHOSPITAL DOCUMENTATION

PURPOSE:

To define the responsibilities and requirements of prehospital personnel and service provider agencies in the initiation, completion and distribution of prehospital documentation.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.202, 1797.204, 1797.220, 1798 and 1798.220.

California Code of Regulations, Title 22, Chapter 2, 3 and 4.

POLICY:

A. Prehospital documentation shall be completed as follows:

1. ALS/LALS/BLS transport and ALS/LALS non-transport prehospital personnel shall complete patient care documentation for every response where patient contact is established.

2. ALS/LALS/BLS transport and ALS/LALS non-transport prehospital personnel shall complete appropriate documentation for all cancelled calls including:

   a. "Code 4" or cancelled calls prior to arrival at scene.

   b. "No patient contact" calls defined as arrival on scene and unable to locate any patient, or no direct interaction with patient.

3. BLS non-transport prehospital personnel shall complete patient care documentation for the following types of responses:

   a. An AED is utilized.

   b. An EMT optional skill is performed.

   c. An RAS/AMA is completed by BLS personnel.

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S-SV EMS Medical Director	**S-SV EMS Regional Executive Director**

B. Prehospital patient care documentation includes the following:

1. A written or electronic Patient Care Report (PCR).

2. An S-SV EMS Interim Patient Care Report (Reference No. 605-A) or an equivalent interim patient care report form utilized in addition to the PCR.

C. A PCR is a legal medical record and the primary source of information for provider, base/modified base hospital and S-SV EMS Agency Continuous Quality Improvement (CQI) review.

D. Prehospital personnel are responsible for providing clear, concise, complete, legible and accurate prehospital documentation.

E. Any form of falsification of prehospital documentation shall be considered a serious infraction subject to disciplinary certification/accreditation action by the S-SV EMS Agency and/or referral to the appropriate licensing authority.

PROCEDURE:

A. PCR UTILIZATION

Prehospital service provider agencies who are required to complete prehospital documentation as indicated by this policy must utilize one of the following forms of documentation:

1. An electronic PCR (ePCR) system:

   a. All S-SV EMS approved ALS/LALS/BLS transport and ALS/LALS non-transport providers must utilize one of the following ePCR systems:

      - The S-SV EMS Agency selected ePCR system, or

      - An equivalent National EMS Information System (NEMSIS) compliant ePCR system.

2. A written PCR:

   a. A written PCR may be utilized by BLS non transport providers for prehospital documentation purposes as required by this policy.

   b. A written PCR shall include, at a minimum, all data elements listed in the following appropriate policy(s):

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

- EMT Optional Skill(s) Service Provider Application, Approval Process, Requirements and Responsibilities, Reference No. 477.

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

B. DOCUMENTATION/COMPLETION OF THE PCR

1. Patient information documented on the PCR provides a medical record of the patient's assessment, history, treatment rendered, response to treatment and all other pertinent medical information regarding the patient.

2. The certification name(s) and certification/license number(s) of appropriate prehospital personnel rendering patient care on a responding unit are required to be documented on the PCR. The primary prehospital patient care provider shall sign the PCR. An electronic signature is acceptable if an ePCR system is utilized for prehospital documentation.

3. All pertinent supporting patient care documentation (including but not limited to completed RAS/AMA forms, DNR/POLST forms, patient medication lists and cardiac monitor strips) shall be attached to the PCR.

C. MINIMUM PATIENT CARE DOCUMENTATION REQUIRED TO BE LEFT WITH THE PATIENT AT THE RECEIVING FACILITY AT TIME OF DELIVERY

The following minimum prehospital patient care documentation, when available to prehospital personnel, shall be completed by the primary patient care provider and left at the receiving facility at the time of patient delivery:

1. Date of incident & incident number
2. Call location
3. EMS unit number
4. Patient name, sex, age, date of birth, address, city and telephone number
5. Chief complaint
6. Patient weight
7. PQRST / time of symptom onset (including time of incident and mechanism of injury for all trauma patients)
8. Pertinent medical history
9. Medications
10. Medication allergies
11. Vital signs (including GCS, BP, pulse, respirations, pain scale, cardiac rhythm and Sp02 as appropriate)
12. Treatment rendered (including time, type of treatment, medication, dose, route, response and total IV volume infused)
13. Name, title and ID of the prehospital provider completing the documentation

There are no exceptions to this requirement. It is the preference of the S-SV EMS Agency that a completed PCR be left at the receiving hospital at the time of patient delivery. However, prehospital personnel may satisfy this requirement with the completion of the S-SV EMS Interim Patient Care Report (Reference No. 605-A) or an equivalent interim patient care report form that includes, at a minimum, all of the information listed above.

D. DISTRIBUTION OF THE COMPLETED PCR

1. The completed PCR shall be distributed as follows:

   a. Service provider agency.

   b. Receiving hospital:

      - In instances when a completed PCR is not left with the patient at the receiving hospital at the time of patient delivery (i.e. when an interim patient care report is utilized), a copy of the completed PCR shall be provided to the receiving hospital within 24 hours.

      - When patient care is transferred from one ALS/LALS provider to another provider for transportation, the ALS/LALS non-transporting provider shall send a copy of their completed PCR to the receiving hospital within 24 hours.

   c. Base/modified base hospital:

      - In instances where a base/modified base hospital is utilized for medical control that is not the receiving facility (including AMA patients and RAS patients that require base/modified base hospital contact), a copy of the completed PCR shall be sent to the base/modified base hospital that was utilized within 24 hours.

   d. S-SV EMS Agency:

      - In instances when an AED or EMT Optional Skill is utilized by a BLS service provider, a copy of the completed PCR shall be sent to the S-SV EMS Agency within 7 calendar days.

2. S-SV EMS service provider agencies shall be responsible for maintaining the PCRs for all patient care responses in accordance with all applicable laws, regulations, Government Codes and policies. The PCR shall be made available to the S-SV EMS Agency upon request.

E. PREHOSPITAL DOCUMENTATION TRAINING

Each service provider agency is responsible for training their appropriate prehospital personnel in the initiation, completion and distribution of required prehospital documentation.

F. PREHOSPITAL DATA SUBMISSION

ePCR data shall be provided to the S-SV EMS Agency in the following manner:

1. Prehospital service providers utilizing the S-SV EMS Agency selected ePCR system shall complete a data sharing agreement with the S-SV EMS Agency.

2. Prehospital service providers not utilizing the S-SV EMS Agency selected ePCR system shall establish a process with the S-SV EMS Agency ePCR vendor to allow for EMS data submission. This data shall include, at a minimum, all NEMSIS data elements. Data shall be submitted to the S-SV EMS Agency data system on a minimum of a monthly basis, no later than the 15th day of the following month.

CROSS REFERENCES:

Prehospital Care Policy Manual

Alternate Transport Vehicle Policy, Reference No. 416

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

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

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

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S-SV EMS Agency Regional QI Tracking Form (Reference No. 620-A)

Send completed forms and a copy of the PCR to the S-SV EMS Agency within seven (7) calendar days
Fax: (916) 625-1730, Email: john.poland@ssvems.com, or Mail: 5995 Pacific Street, Rocklin. CA 95677

QI Incident Reporting Information:

☐ Nasotracheal intubation ☐ Pediatric intubation (≤ 14 years old) ☐ ROSC patient transported to a STEMI receiving center that was not the closest acute care receiving hospital	
Agency name:	Reporting party name:
Incident date:	Incident #:
Nasotracheal Intubation Details	
Reason for nasotracheal intubation:	
Number of attempts: ☐ Successful ☐ Unsuccessful	ET tube size:
Endotrol ET tube used: ☐ Yes ☐ No	BAAM used: ☐ Yes ☐ No
Was sedation utilized (base/modified base order): ☐ Yes ☐ No Type/Dose:	
Pediatric Intubation Details	
Reason for pediatric intubation:	
Number of attempts: ☐ Successful ☐ Unsuccessful	ET tube size:
Laryngoscope blade type: ☐ Miller ☐ Macintosh	Laryngoscope blade size:
ROSC Patient Transport Details	
Cardiac arrest witnessed by: ☐ No one/Unknown ☐ Bystander ☐ EMS	Estimated down time:
Bystander CPR: ☐ Yes ☐ No	AED utilized: ☐ Yes ☐ No # of shocks:
Reoccurrence of cardiac arrest in the prehospital setting after ROSC: ☐ Yes ☐ No	
Type of CPR: ☐ Manual ☐ Mechanical Total CPR time:	Initial rhythm:
Estimated additional transport time to the STEMI receiving center vs the closest receiving hospital:	

Description of issues/complications/concerns:

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 701

SUBJECT: PREHOSPITAL PROVIDER AGENCY INVENTORY REQUIREMENTS

PURPOSE:

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

AUTHORITY:

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

California Code of Regulations, Title 22, Division 9

California Code of Regulations, Title 13

California Vehicle Code, Section 2418.5

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

POLICY:

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

For inventory list see attached table

Effective Date: 09/01/2013 **Date last Reviewed/Revised: 09/13**
Next Review Date: As Needed
Approved:

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S-SV EMS Medical Director	**S-SV EMS Regional Executive Director**

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
RADIO EQUIPMENT							
Mobile UHF Med-Net Radio	1	Opt. - 1	0	1	Opt. - 1	1	0
Portable UHF Med-Net Radio **OR** Portable Cell Phone	1	1	1	1	1	1	0
MISCELLANEOUS EQUIPMENT & SUPPLIES							
Maps (paper or electronic covering the areas where service is provided)	1	1	0	1	1	1	1
D.O.T Emergency Response Guidebook	1	1	0	1	1	1	1
FIRESCOPE Field Operations Guide (FOG)	1	1	0	1	1	1	1
Hazardous Materials medical management reference	1	1	0	1	1	1	1
Approved ePCR	1	1	1	1	1	1	Optional
RAS/AMA Forms	10	5	5	10	5	5	Optional
Triage Tags (included in triage kit for transport providers)	10	10	0	10	10	10	10
Triage Kit in a folio or gear bag to include the following minimum items: MCI vests for Triage and Medical Group Supervisor positions, pens/pencils, trauma sheers, clipboard, Patient Trasnsportation Summary Worksheets, START Traige reference sheet, barrier tape, and glow sticks	1	Opt. - 1	0	1	Opt. - 1	1	Opt. - 1
Infection control packs (per crew member)	1 pk each	1 pk each	1 pk	1 pk each	1 pk each	1 pk each	1 pk each
Antiseptic hand wipes **or** waterless hand sanitizer	10/1	10/1	5/1	10/1	10/1	10/1	10/1
Covered waste container (red bio hazard bags acceptable)	1	1	0	1	1	1	1
Adult & Pediatric BP cuff	1 each	1 each	1 each	1 each	1 each	1 each	1 each
Thigh BP cuff	1	1	0	1	1	1	1
Stethoscope	1	1	1	1	1	1	1
Flashlight or Penlight	1	1	1	1	1	1	1
Bedpan or Fracture pan	1	0	0	1	0	1	0
Urinal	1	0	0	1	0	1	0
Sharps container	1	1	1	1	1	1	0
Padded soft wrist & ankle restraints	1 set	Opt. - 1 set	0	1 set	Opt. - 1 set	1 set	0
Pillows, sheets, pillow cases, towels	2 each	0	0	2 each	0	2 each	0
Blankets	2	1	0	2	1	2	1
Emesis basin/disposable emesis bags	2	1	0	2	1	2	1
Length based Pediatric Resuscitation Tape (Broselow)	1	1	1	1	1	0	0
Ambulance cot with straps to secure patient to cot and necessary equipment to properly secure cot in vehicle	1	0	0	1	0	1	0

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
MISCELLANEOUS EQUIPMENT & SUPPLIES (continued)							
Collapsible stretcher, breakaway flat, or similar device	1	0	0	1	0	1	0
Thermometer (optional)	Opt. - 1	Opt. - 1	0	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1
BIOMEDICAL EQUIPMENT & SUPPLIES							
Pulse Oximeter	1	1	1	1	1	Opt. - 1	Opt. -1
Automatic External Defibrillator (AED) - with adult patches (pediatric patches are recommended but optional). ***Required in place of portable monitor/defibrillator and supplies listed in this section for LALS providers who utilize non-AEMT II personnel.	0	0	0	1*	1*	Opt. - 1	Opt. - 1
AED with cardiac monitoring and manual defibrillation capabilities (in place of portable monitor/defibrillator for bike teams only)	0	0	1	0	0	0	0
Portable Monitor/Defibrillator - battery operated, with ECG printout, capable of synchronized cardioversion, transcutaneous pacing & 12-Lead (waveform capnography optional). ***Required in place of AED for LALS providers who utilize AEMT II personnel (Transcutaneous pacing capabilities not approved or required for LALS providers).	1	1	0	1*	1*	0	0
Spare monitor/defibrillator/AED battery	1	1	as needed	1	1	as needed	as needed
Adult hands free defibrillator patches **OR** defibrillator paddles with defibrillation gel pads or paddle conduction gel	2 sets	2 sets	2 sets	2 sets	2 sets	0	0
Pediatric hands free defibrillator patches OR defibrillator paddles with defibrillation gel pads or paddle conduction gel	1 set	1 set	1 set	1 set	1 set	0	0
Electrode leads (wires) *(AEMT II Providers Only)	2 sets	1 set	1 set	2 sets*	1 set*	0	0
ECG paper *(AEMT II Providers Only)	2 rolls	1 roll	as needed	2 sets*	1 set*	0	0
Adult/pediatric disposable ECG electrodes (10/set) *(AEMT II Providers Only)	4 sets	2 sets	2 sets	4 sets	2 sets	0	0
Capnometer (optional)	Opt. - 1	Opt. - 1	Opt. - 1	0	0	0	0
Co-Oximeter (optional)	Opt. - 1	Opt. - 1	Opt. - 1	0	0	0	0
Glucometer	1	1	1	1	1	0	0
Glucometer test strips	10	5	5	10	5	0	0
Lancets	10	5	5	10	5	0	0

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

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

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
AIRWAY/OXYGEN EQUIPMENT & SUPPLIES (cont.)							
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	1 each	1 each	0	0	0	0
Endotracheal tube stylettes - neonatal, child & adult	1 each	1 each	1 each	0	0	0	0
Flex Guide ETT introducer - caude tip 15 fr x 70 cm	2	1	1	0	0	0	0
Advanced Airway tube holder *S-SV EMS approved EMT optional skill providers only	2	1	1	2	1	2*	1*
Esophageal Tracheal Airway Device - Adult 37 and 41 Fr OR King Airway Device - Size 3, Size 4, Size 5 *S-SV EMS approved EMT optional skill providers only	1 each	1 each	0	1 each	1 each	1 each*	1 each*
End tidal CO2 detector device - disposable single patient use colorimetric device (adult & pediatric) or disposable capnography/capnometer circuit *S-SV EMS approved EMT optional skill providers only	2 each	1 each	1 each	2 each	1 each	2 each*	1 each*
Esophageal Intubation Detector Device (EDD) (optional for ALS providers using waveform capnography or capnometer) *S-SV EMS approved EMT optional skill providers only	2	1	1	2	1	1*	1*
Meconium aspirator	1	Opt. - 1	0	0	0	0	0
Airway airflow monitor (optional)	Opt. - 2	Opt. - 2	Opt. - 1	0	0	0	0
Inspiratory Impedance Threshold Device (optional)	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1
S-SV approved disposable CPAP circuit with mask	2	1	0	2	1	Opt. - 1	Opt. - 1
Manual Jet Ventilator device (including Adult & Pediatric Transtracheal Catheter or minimum 12 ga x 3 " catheter) **OR** ENK Flow Modulator Kit	1	1	1	0	0	0	0
Needle thoracostomy kit with minimum 14 ga X 3 " catheter specifically designed for needle decompression	1	1	1	0	0	0	0
IMMOBILIZATION EQUIPMENT & SUPPLIES							
Ked	1	Opt. - 1	0	1	Opt. - 1	1	Opt. - 1
Long spine board with straps	2	1	0	2	1	2	1
Pediatric spine board	1	1	0	1	1	1	Opt. - 1
Head immobilization set	2	1	0	2	1	2	1
Traction splint: Hare, Sager or equivalent	1	1	0	1	1	1	Opt. - 1
Arm & leg splints (i.e. cardboard, SAM type, vacuum)	2 each	2 each	0	2 each	2 each	2 each	2 each

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
IMMOBILIZATION EQUIPMENT & SUPPLIES (continued)							
Tape (optional) - type approved by SSV LEMSA Medical Director	Opt. - 1 roll	Opt. - 1 roll	0	Opt. - 1 roll	Opt. - 1 roll	Opt. - 1 roll	Opt. - 1 roll
Cervical Collars (rigid): Large, medium, small & pediatric **OR** adjustable adult & pediatric	2 each	2 each	Opt. - 1 ea.	2 each	2 each	2 each	2 each
OBSTETRICAL EQUIPMENT & SUPPLIES							
OB Kit containing a minimum: sterile gloves, umbilical cord tape or clamps (2), dressings, towels, bulb syringe, stocking cap, and clean plastic bags.	2	1	1	2	1	2	1
BANDAGING EQUIPMENT & SUPPLIES							
Band-Aids	10	10	10	10	10	10	10
Adhesive tape rolls 1" & 2" rolls	2 each	1 each	1 each	2 each	1 each	2 each	1 each
Non sterile 4x4 compresses	50	10	10	50	10	50	10
Sterile 4x4 compresses	10	5	5	10	5	10	5
Surgipads (optional)	Opt. 4	Opt. 2	Opt. 2	Opt. 4	Opt. 2	Opt. 4	Opt. - 2
Trauma dressing (10"x30" or larger universal dressings)	2	1	1	2	1	2	1
S-SV EMS Agency approved Hemostatic Agents: (QuickClot® Emergency 4x4 & QuickClot® Combat Gauze Z-Fold or Celox® Rapid Z-Fold Gauze)	Opt. - 1 each	Opt. - 1 each	Opt. - 1 each	Opt. - 1 each	Opt. - 1 each	Opt. - 1 each	Opt. - 1 each
Kling/Kerlix in 2", 3" or 4" rolls	5	2	2	5	2	5	2
Sterile petroleum impregnated dressing	2	2	1	2	2	2	2
Asherman Chest Seal (optional)	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1
Triangle bandages	4	2	2	4	2	4	2
S-SV EMS Agency approved commercial tourniquet device (optional)	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1
Cold packs and heat packs	4 each	2 each	2 each	4 each	2 each	4 each	2 each
Gloves (unsterile) various sizes	10 pr each	10 pr each	2 pr each	10 pr each	10 pr each	10 pr each	10 pr each
Morgan lens (optional)	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1	Opt. - 1
1000 mL sterile irrigation solution	2	1	0	2	1	2	1
Potable water	2 liters	2 liters	0	2 liters	1 liter	2 liters	1 liter
Bandage shears	1 pr	1 pr	1 pr	1 pr	1 pr	1 pr	1 pr
IV/MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES							
Catheter over needle - 14 ga, 16 ga, 18 ga, 20 ga	6 each	2 each	2 each	6 each	2 each	0	0
Catheter over needle - 22ga, 24ga	2 each	2 each	2 each	2 each	2 each	0	0
Micro-drip & Macro-drip venosets **OR** Selectable drip tubing	4 each	2 each	1 each	4 each	2 each	0	0

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
IV/MEDICATION ADMINISTRATION EQUIPMENT & SUPPLIES (cont.)							
Blood administration tubing (optional)	Opt. - 2	Opt - 1	0	Opt. - 2	Opt. - 1	0	0
IV extension	4	2	1	4	2	0	0
Saline Locks (optional)	Opt. - 2	Opt. - 1	Opt. - 1	Opt. - 2	Opt. - 1	0	0
IV start pack or equivalent with tourniquets	4	2	2	4	2	0	0
Alcohol wipes	20	10	5	20	10	20	10
Chlorhexidine swabs/skin prep	5	5	2	5	5	optional	optional
TB/1 mL syringe	3	2	2	3	2	0	0
3 - 5 mL syringe *S-SV EMS Agency approved EMT Optional Skill providers only (Naloxone)	3	2	2	3	2	Opt. - 2*****	Opt. - 2*****
10 - 12 mL syringe	3	2	2	3	2	0	0
20 mL syringe	1	1	1	1	1	0	0
50 - 60 mL syringe	1	0	0	1	0	0	0
22 ga, 25 ga safety injection needles	2 each	2 each	2 each	2 each	2 each	0	0
Filter needle (only required if utilizing medication in ampules) *S-SV EMS Agency approved EMT Optional Skill providers only (Naloxone)	2	2	2	2	2	Opt. - 2*****	Opt. - 2*****
Vial access cannulas *S-SV EMS Agency approved EMT Optional Skill providers only (Naloxone)	2	2	2	2	2	Opt. - 2*****	Opt. - 2*****
Mucosal Atomization Device (MAD) *S-SV EMS Agency approved EMT Optional Skill providers only (Naloxone)	2	2	0	2	2	Opt. - 2*****	Opt. - 2*****
Arm boards - (short, long)	2 each	1 each	0	2 each	1 each	0	0
Vacutainer holder, needle & blood tubes (optional)	Optional	Optional	0	Optional	Optional	0	0
10 mL NS vials or pre-filled syringes for injection/flush	Opt. - 2	Opt. - 1	Opt. - 1	Opt. - 2	Opt. - 1	0	0
INTRAOSSEOUS ACCESS EQUIPMENT & SUPPLIES							
ALS providers must stock the necessary equipment and supplies to establish IO access on both an adult and pediatric patient/LALS providers must stock the necessary equipment and supplies to establish IO access on a pediatric patient as indicated below:							
Pediatric IO Devices (ALS/LALS providers must stock one of the following devices in the minimum quantity listed)							
Jamshidi ® Illinois device with 15 ga adjustable length needle	2	1	1	2	1	0	0
Bone Injection Gun (B.I.G. ®) - Pediatric	2	1	1	2	1	0	0
EZ-IO ® 15 mm Pediatric Needle Set (including a minimum of 1 EZ-IO ® Power Driver used for both adult and pediatric patients)	2	1	1	2	1	0	0

Sierra-Sacramento Valley EMS Agency
EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	ALS Non Transport	ALS BIKES	LALS Transport	LALS Non Transport	BLS Transport	BLS Non Transport
INTRAOSSEOUS ACCESS EQUIPMENT & SUPPLIES (cont.)							
Adult IO Devices (ALS providers must stock one of the following devices in the minimum quantity listed)							
Bone Injection Gun (B.I.G. ®) - Adult	2	1	1	0	0	0	0
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	0	0	0	0
IV SOLUTIONS							
Lactated Ringers - 1000 mL bag (optional)	Opt. - 2	Opt. 1	0	Opt. - 2	Opt. - 1	0	0
Normal saline - 1000 mL bag	6	2	2	6	2	0	0
Normal saline - 250 mL bag	2	1	0	2	1	0	0
MEDICATIONS							
Activated charcoal (50 gm)	1	Opt. - 1	0	1	Opt. - 1	0	0
Adenosine 6 mg - vial or pre-filled syringe	5	3	3	0	0	0	0
Albuterol - 2.5mg (pre-mixed w/NS). If not premixed; Normal Saline 2.5 mL, without preservatives, is required for dilution of each dose.	6	4	2	6	4	0	0
Amiodarone 3 ml - 150 mg (50 mg/ml)	6	3	3	0	0	0	0
Aspirin (chewable)	8	8	8	8	8	0	0
Atropine 1 mg/1ml vial or 1 mg/10 ml preload syringe *LALS providers who use AEMT II personnel only	4	2	2	4*	2*	0	0
Benadryl (50 mg/ml)	2	2	2	0	0	0	0
Benadryl Elixir - 100 mg	1	1	1	0	0	0	0
Calcium Chloride 10% - (1 gm/10ml)	4	2	1	0	0	0	0
Dextrose 50% (25gm/50ml)	2	2	1	2	2	0	0
Dextrose 25% (2.5gm/10ml)	2	1	0	2	1	0	0
Dopamine 400 mg	1	Opt. - 1	0	0	0	0	0
Epinephrine 1:1,000 Auto Injector: Adult 0.3 mg/Pediatric 0.15 mg *S-SV EMS Agency approved EMT Optional Skill providers only	0	0	0	0	0	Opt. - 1 ea*	Opt. - 1 ea*
Epinephrine 1:1,000	5 mg	5 mg	5 mg	5 mg	5 mg	0	0
Epinephrine 1:10,000 (1mg/10ml) *LALS providers who use AEMT II personnel only	8	4	4	8*	4*	0	0
Glucagon 1mg (1unit)	1	1	1	1	1	0	0
Glucose paste **OR** Glucose solution (oral prepackaged)	2	1	1	2	1	2	1

Sierra-Sacramento Valley EMS Agency

EQUIPMENT AND SUPPLY SPECIFICATIONS

	MINIMUM QUANTITY REQUIRED						
	ALS Transport	**ALS Non Transport**	**ALS BIKES**	**LALS Transport**	**LALS Non Transport**	**BLS Transport**	**BLS Non Transport**
MEDICATIONS (cont.)							
Lidocaine HCl 2% (100mg/5ml) - IO use ALS/antiarrhythmic LALS *LALS providers who use AEMT II personnel only	1	1	1	6*****	3*****	0	0
Mark-I/Duo Dote Nerve Agent Antidote Kits *S-SV EMS Agency approved EMT Optional Skill providers only	Optional	Optional	Optional	Optional	Optional	Optional*	Optional*
Naloxone (Narcan) 2.0 mg (1mg/ml concentration) *S-SV EMS Agency approved EMT Optional Skill providers only	4	2	2	4	2	Opt. - 2*****	Opt. - 2*****
Nitroglycerin 0.4 mg/tab (1/150) bottle **OR** Nitroglycerine spray actuation	2	1	1	2	1	0	0
Pralidoxime Chloride (2-PAM) 1 gm/20 ml vial (optional)	Optional	Optional	Optional	0	0	0	0
Sodium Bicarbonate (50mEq/50ml) *LALS providers who use AEMT II personnel only	2	1	1	2*****	1*****	0	0
Zofran (4mg/2ml vial)	8	2	2	0	0	0	0
Zofran Oral Disentregrating Tablets (ODT) 4 mg	4	2	2	0	0	0	0
CONTROLLED SUBSTANCE MEDICATIONS, TRACKING AND STORAGE EQUIPMENT							
1. Paramedic providers have the option of stocking and utilizing either morphine, fentanyl, or a combination of the two. 2. The **minimum** opioid stocking requirement is 20 mg morphine equivalent (20 mg morphine, 200 mcg fentanyl, or a combination of the two). 3. The **maximum** opioid stocking requirment is 100 mg morphine equivalent (100 mg morphine, 1000 mcg fentanyl, or a combination of the two). 4. Fentanyl is not in the AEMT scope of practice and may not be stocked or utilized by AEMT II provider personnel. 5. Controlled substance stocking and utilization are optional for ALS and LALS (AEMT II) bike teams. If bike teams choose to stock and utilize controlled substances they are limited to the maximum quantities listed below (20 mg midazolam and 20 mg opioid morphine equivalent).							
Benzodiazapine							
Midazolam (Versed) 5 mg/ml concentration (minimum-maximum) *LALS providers who use AEMT II personnel only	20-60 mg	20-60 mg	Optional (max 20 mg)	20-60 mg*	20-60 mg*	0	0
Opioids							
Fentanyl 100 mcg/2 ml (minimum-maximum)	200 - 1000 mcg	200 - 1000 mcg	Optional (20 mcg)	0	0	0	0
Morphine HCL 10 mg/ml unit dose (minimum-maximum) *LALS providers who use AEMT II personnel only	20-100 mg	20-100 mg	Optional (20 mg)	20-100 mg*	20-100 mg*	0	0
Controlled Substances Tracking and Storage							
Controlled substance log sheet *LALS providers who use AEMT II personnel only	1	1	1	1*****	1*****	0	0
Double lock container system for controlled meds *LALS providers who use AEMT II personnel only	1	1	1	1*****	1*	0	0

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 702

SUBJECT: FIRELINE PARAMEDIC INVENTORY

PURPOSE:

To establish a standardized inventory for S-SV EMS Agency accredited paramedics when responding to and providing Advanced Life Support (ALS) care on the fireline at wildland fires.

This policy applies to S-SV EMS Agency approved Fireline Paramedic program providers when requested through the statewide Fire and Rescue Mutual Aid System.

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

FIRESCOPE California Fireline Emergency Medical Technician – Paramedic Incident Command Systems Position Manual (FEMP ICS 223-11), June 2013

POLICY:

A. S-SV EMS Agency accredited paramedics responding to wildland fires to provide ALS care on the fireline shall carry the items listed in this policy 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.

B. The Fireline Paramedic shall report to the incident with the full complement of EMS supplies ready to work. The Incident Medical Unit will re-supply the Fireline Paramedic to the best of their ability.

C. Providers should stock sufficient quantities of medical supplies and medications, especially controlled substances, to avoid the need for mid-incident restock. Incident Medical Units may not be capable of re-supplying controlled substances.

D. Controlled substances shall be secured in accordance with S-SV EMS Agency 'Management of Controlled Substances' policy (Reference No. 710) and the providers' policies and procedures.

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BASIC LIFE SUPPORT (BLS) PACK INVENTORY

- ☐ FEMP pack inventory sheet (1)
- ☐ PCR (6)
- ☐ RAS/AMA forms (3)
- ☐ Writing pad (1)
- ☐ Pen and pencil (1 ea.)
- ☐ Triage tags (6)
- ☐ Biohazard bags (2)
- ☐ Exam gloves (box)
- ☐ Mask, disposable w/eye shield (1)
- ☐ Antiseptic hand wipes (10)
- ☐ Space blanket (2)
- ☐ Pen light or flashlight (1)
- ☐ Bandage shears (1)
- ☐ BP cuff, adult (1)
- ☐ Stethoscope (1)
- ☐ Thermometer, digital (1)
- ☐ Adult BVM (1)
- ☐ NPA kit (1)
- ☐ OPA kit (1)
- ☐ Manual suction device (1)
- ☐ Tape, 1" cloth (2 rolls)
- ☐ Bandage, sterile 4x4 (6)
- ☐ Bandage, triangular (2)
- ☐ Kerlix/Kling, 2.5" (4)
- ☐ Coban wraps/ace bandage (2 ea.)
- ☐ Petroleum dressing (2)
- ☐ Burn sheet (2)
- ☐ Trauma dressing (4)
- ☐ Approved tourniquet device (2)
- ☐ Cervical collar, adjustable (1)
- ☐ Splint, moldable (1)
- ☐ Cold pack (3)
- ☐ Eye wash (1)
- ☐ Splinter kit (1)

ADVANCED LIFE SUPPORT (ALS) PACK INVENTORY

AIRWAY

- ☐ ETT with stylette (6.5 & 7.5) (1 ea.)
- ☐ Laryngoscope blades Mac 4 & Miller 4 (light-weight disposable recommended) (1 ea.)
- ☐ Laryngoscope handle (pediatric handle recommended to reduce weight) (1)
- ☐ End Tidal CO_2 detector (1)
- ☐ ETT restraint (1)
- ☐ ETT verification device (1)
- ☐ Beck Airway airflow monitor (BAAM) (1)
- ☐ Needle thoracostomy kit (1)
- ☐ King Airway (1)
- ☐ Water soluble lubricant (1)
- ☐ 2% lidocaine jelly (1 tube)
- ☐ Topical vasoconstrictor (1)

IV/MED ADMIN. SUPPLIES

- ☐ 1 mL TB syringe (2)
- ☐ 10 mL syringe (2)
- ☐ 18 ga. Needle (4)
- ☐ 25 ga. Needle (2)
- ☐ Mucosal Atomizer Device (2)
- ☐ IV Catheters (2 ea) 14, 16, 18, & 20 ga.
- ☐ Alcohol preps (6)
- ☐ Betadine swabs (4)
- ☐ IV start pack with venaguard & tourniquet (2)
- ☐ Transpore tape (1 roll)
- ☐ Razor (1)
- ☐ IV Administration Set-Macro-Drip (2)
- ☐ Sharps container (1)
- ☐ Glucometer test strips (4)
- ☐ Lancet (4)
- ☐ EZ-IO® or B.I.G. for adult IO access (optional)

SUBJECT: FIRELINE PARAMEDIC INVENTORY

BIOMEDICAL EQUIPMENT

- ☐ Compact Semi-Automatic Defibrillator (SAD) with screen (1)
- ☐ SAD adult patches (2)
- ☐ SAD spare battery, electrode wires, EKG paper, and disposable adult electrodes if necessary (depending on SAD model)
- ☐ Glucometer (1)
- ☐ Pulse Oximeter (1 Optional)

MEDICATIONS

- ☐ Aerosolized Beta 2 specific bronchodilator with spacer (1)
- ☐ Amiodarone – 150 mg (3)
- ☐ Aspirin chewable – 81 mg (20 tablets)
- ☐ Atropine sulfate – 1 mg (2)
- ☐ Dextrose 50% – 25 G (1)
- ☐ Diphenhydramine – 50 mg (4)

MEDICATIONS (continued)

- ☐ Diphenhydramine elixir – 100 mg (1)
- ☐ Epinephrine 1:1,000 – 1 mg (4)
- ☐ Epinephrine 1:10,000 – 1 mg (2)
- ☐ Glucagon – 1 mg/unit (1)
- ☐ Glucose Paste (1)
- ☐ Naloxone – 2 mg (2)
- ☐ Nitroglycerine (10 doses)
- ☐ NS IV – 1,000 ml – can be configured into two 500 ml or four 250 ml bags

CONTROLLED SUBSTANCES

- ☐ Midazolam – 20 mg
- ☐ Opioid analgesic (morphine, fentanyl, or both) – 60 mg morphine equivalent
- ☐ Double lock container system
- ☐ Controlled substance log sheet (1)
- ☐ Controlled substance seals (4)

CROSS REFERENCES:

Prehospital Care Policy Manual

Auto Aid/Mutual Aid/Out-Of-Region Response, Reference No. 461

Management of Controlled Substances, Reference No. 710

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 710

SUBJECT: MANAGEMENT OF CONTROLLED SUBSTANCES

PURPOSE

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

AUTHORITY

Code of Federal Regulations, Title 21

California Health & Safety Code, Division 10

California Health & Safety Code, Division 2.5

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

POLICY

A. S-SV EMS Agency approved controlled substances:

1. Fentanyl
2. Midazolam (Versed)
3. Morphine Sulfate

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

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

C. Prehospital Service Provider Agency Policies and Procedures

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

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a. Controlled substance ordering and order tracking

b. Controlled substance receipt and accountability

c. Controlled substance master supply storage, security and documentation

d. Controlled substance labeling and tracking

e. Controlled substance vehicle storage and security

f. Controlled substance usage procedures and documentation

g. Controlled substance reverse distribution

h. Controlled substance disposal

i. Controlled substance re-stocking procedures

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

a. Controlled substance testing

b. Controlled substance discrepancy reporting

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

d. Controlled substance usage audits.

D. Security of Narcotics

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

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

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

4. Each ALS/LALS unit shall maintain a standardized written record of the controlled substance inventory. That record shall be considered a permanent record. Once completed, controlled substance inventory and administration

records shall be maintained in accordance with State and Federal Law and Regulation.

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

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

E. Controlled Substances Administered to Patients

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

2. The following information must be documented on a controlled substance administration record.

   a. Date administered

   b. Time administered

   c. Unit number

   d. Patient name

   e. Drug administered

   f. Amount administered

   g. Paramedic/AEMT II signature and number

   h. If only a portion of the medication was administered to the patient, the remainder shall be wasted in the presence of a registered nurse or physician at the receiving hospital, or the ALS/LALS service provider's immediate supervisor. Both parties shall document this action on the controlled substance administration form.

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

CROSS REFERENCES

Prehospital Care Policy Manual

Prehospital Provider Agency Inventory Requirements, Reference No. 701

AEMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

SIERRA-SACRAMENTO VALLEY EMS AGENCY

FIELD POLICIES & TREATMENT PROTOCOLS
SECTION VIII

SUBJECT: INDEX **REFERENCE NO. 800**

SUBJECT: INDEX REFERENCE NO. 800

Adult Patient Treatment Protocols (BLS/ALS)

Environmental

Trauma

Pediatric Patient Treatment Protocols (BLS/ALS)

Adult Patient Treatment Protocols (LALS)

Cardiovascular (LALS)

Respiratory (LALS)

Medical (LALS)

Neurological (LALS)

SUBJECT: INDEX **REFERENCE NO. 800**

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 803

SUBJECT: PARAMEDIC SCOPE OF PRACTICE

PURPOSE:

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

AUTHORITY:

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

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

PRINCIPLES:

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

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

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

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

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

3. Base/modified base hospital contact is required by all paramedics to perform the procedure(s) and/or administer medications(s) that are identified in S-SV EMS Agency policies/protocols as base hospital order only or base/modified base hospital physician order only.

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4. Direct medical supervision as outlined in the S-SV EMS Agency 'Physician on Scene' policy (Reference No. 839).

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

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

POLICY:

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

BASIC SCOPE OF PRACTICE:

A. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).
B. Perform defibrillation, synchronized cardioversion, and external cardiac pacing.
C. Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with Magill forceps.
D. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.
E. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP).
F. Institute intravenous (IV) catheters, saline locks, needles, or other cannula (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.
G. Institute intraosseous (IO needles or catheters).
H. Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
I. Obtain venous blood samples.
J. Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).

K. Utilize Valsalva maneuver.
L. Perform percutaneous needle cricothyroidotomy.
M. Perform needle thoracostomy.
N. Monitor thoracostomy tubes.
O. Monitor and adjust IV solutions containing potassium ≤ 40 mEq/L.
P. Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.
Q. Administer, using prepackaged products when available, the following medications:
    1. 10%, 25% and 50% dextrose;
    2. activated charcoal;
    3. adenosine;
    4. aerosolized or nebulized beta-2 specific bronchodilators – albuterol;
    5. amiodarone;
    6. aspirin;
    7. atropine sulfate;
    8. calcium chloride;
    9. diphenhydramine hydrochloride;
    10. dopamine hydrochloride;
    11. epinephrine;
    12. fentanyl
    13. glucagon;
    14. midazolam;
    15. lidocaine hydrochloride;
    16. magnesium sulfate;
    17. morphine sulfate;
    18. naloxone hydrochloride;
    19. nitroglycerin preparations, except intravenous;
    20. ondansetron;
    21. pralidoxime chloride;
    22. sodium bicarbonate.

LOCAL OPTIONAL SCOPE OF PRACTICE:

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

A. Adult nasotracheal intubation
B. Pediatric oral endotracheal intubation

EXPANDED SCOPE OF PRACTICE FOR PARAMEDIC INTERFACILITY TRANSPORT:

A. Only paramedics who have successfully completed training program(s) approved by the S-SV EMS Agency Medical Director and employed by an ALS Ambulance

provider approved for paramedic transport of interfacility transport optional skills by the S-SV EMS Agency Medical Director will be permitted to provide the service of using or monitoring the following during interfacility transports:

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

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

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

CROSS REFERENCES:

Policy and Procedure Manual

Paramedic Accreditation to Practice, Reference No. 913

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

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

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 812

SUBJECT: BASE/MODIFIED BASE/RECEIVING HOSPITAL CONTACT

PURPOSE:

To provide for delineation of the circumstances in which prehospital personnel shall make base/modified base/receiving hospital contact for medical control and/or patient notification purposes.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.2, 1798.102

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

POLICY:

A. Prehospital personnel shall make appropriate hospital contact in a timely manner according to the requirements contained in this policy.

B. Base/modified base hospital contact is required by EMS personnel to perform any procedure(s) and/or administer any medications(s) that are identified in S-SV EMS Agency policy/protocol as 'Base/Modified Base Hospital Physician Order Only'. In the event of communication failure those procedures/medications shall not be performed/administered.

C. When requesting to speak directly to a base/modified base hospital physician, EMS personnel shall advise the hospital staff member who initially answers the telephone or radio of the reason for the request (AMA approval, destination consultation, medication or procedure approval, treatment consultation, etc.).

PROCEDURE:

A. Contact with the base/modified base hospital that is in closest proximity to the incident shall be made for any of the following circumstances:

1. For authorization to administer medications and/or perform field procedures that are delineated in S-SV EMS policies and protocols as "Base/Modified Base Hospital Physician Order Only."

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S-SV EMS Medical Director	**S-SV EMS Regional Executive Director**

2. For any of the following classes of patients refusing assessment, treatment and/or transportation:

   a. Released at Scene (RAS) patients meeting the following criteria:

      - Previously Released at Scene (RAS) within the previous 24 hours
      - Children 3 years of age or under
      - Patients age 4 - 17 years old without a responsible adult signature

   b. All patients refusing assessment, treatment and/or transportation Against Medical Advice (AMA).

3. For destination consultation on the following types of patients:

   a. Trauma patients who meet the following criteria as defined in S-SV EMS 'Trauma Triage Criteria" policy (Reference No. 860).

      - Anatomic and/or Physiologic criteria when the time closest trauma center is a Level III Trauma Center (Note: contact shall be made with that Level III Trauma Center for these patients)
      - 'Mechanism of Injury Criteria' only, with or without meeting any of the 'Special Considerations Criteria'.
      - 'Special Considerations Criteria' only when prehospital personnel determine that transport to a trauma center may be in the best interest of the patient.

   b. When there is initiation of an ALS/LALS protocol and transport to a facility other than the most accessible is being considered

      EXCEPTION:

      The following types of patients meeting criteria for transport directly to a designated specialty care facility:

      - STEMI patients identified with a 12 Lead EKG

        If a STEMI patient identified with a 12 Lead EKG is within the authorized catchment area of a designated STEMI receiving center, contact shall be made directly with the designated STEMI receiving center.

      - Stroke patients

        If a patient is identified as meeting stroke symptom criteria and the patient is within the authorized catchment area of a designated stroke receiving center, contact shall be made directly with the stroke receiving center.

- Trauma patients

  If a patient meets Anatomic and/or Physiologic Trauma Triage Criteria, contact shall be made with the appropriate designated trauma center.

  Note – These exceptions do not apply to patients that require transport to the closest facility (i.e. – unable to establish an airway, CPR in progress)

4. For any patient who, in the opinion of the EMS field provider, requires the additional input or judgment of the base/modified base hospital for appropriate management.

B. Prehospital personnel shall make contact directly with the destination facility, in a timely manner, for any patient who does not meet the above criteria or when base/modified base contact is made and the patient is authorized/directed to be transported to a facility other than the base/modified base hospital initially contacted.

CROSS REFERENCES:

Policy and Procedure Manual

Patient Destination, Reference No. 505

Hospitals Capabilities, Reference No. 505-A

Cardiovascular "STEMI" Receiving Centers, Reference No. 506

Stroke System Triage and Patient Destination, Reference No. 507

Trauma Triage Criteria, Reference No. 860

Communication Failure, Reference No. 890

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

Suspected CVA/Stroke, Reference No. N-3

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 820

SUBJECT: DETERMINATION OF DEATH: PUBLIC SAFETY, EMT, AEMT, & PARAMEDIC PERSONNEL

PURPOSE:

This policy provides criteria for Public Safety, EMT, Advanced EMT (AEMT), and paramedic personnel to determine death in the prehospital setting.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.220, 1798.6.

California Code of Regulations, Title 22, Division 9.

POLICY - PUBLIC SAFETY, EMT, AEMT OR PARAMEDIC PERSONNEL:

CPR need not be initiated and may be discontinued for patients who meet the criteria for "Obviously Dead".

OBVIOUSLY DEAD: Persons who, in addition to the absence of respiration, cardiac activity, and neurological reflexes have one or more of the following:

A. Decapitation

B. Decomposition

C. Incineration of the torso and/or head

D. Exposure, destruction, and/or separation of the brain or heart from the body

E. Rigor Mortis

F. A valid Do Not Resuscitate (DNR) form or medallion in accordance with the S-SV EMS Agency 'Do Not Resuscitate' policy, Reference No. 823. Note: This applies regardless of the cause of death (e.g. person with a terminal illness who is a trauma victim).

PROCEDURE – OBVIOUSLY DEAD:

A. The initial assessment shall include a visual and physical examination. The examination shall be conducted in close proximity and with sufficient lighting to assure the existence of the obviously dead criteria.

B. The body and scene should be disturbed as little as possible to protect potential crime scene evidence. An immediate request for law enforcement shall be made. See S-SV Policy, 'Crime Scene Management', Reference No. 825.

C. If the determination of death is based on **RIGOR MORTIS**, **ALL** of the following specific assessments shall be completed and documented.

1. Assessment to confirm absence of respiration:

   a. Assess the patient's airway.

   b. Look, listen, and feel for respirations. This shall include auscultation of the lungs for a minimum of 30 seconds.

2. Assessment to confirm absence of pulse:

   a. Palpate the carotid pulse for a minimum of 30 seconds.

   b. Auscultate the apical pulse for a minimum of 30 seconds.

3. Assessment to confirm absence of neurological response:

   a. Check for pupil response with a penlight or flashlight.

   b. Check for a response to painful stimuli.

A positive response to any of the above assessments requires immediate resuscitative intervention unless the patient has a valid "Do Not Resuscitate (DNR)" order. See S-SV Policy, 'Do Not Resuscitate' - Reference No. 823.

4. Assessment to confirm **RIGOR MORTIS**:

   a. Confirm muscle rigidity of the jaw by attempting to open the mouth.

   b. Confirm muscle rigidity of one arm by attempting to move the extremity.

IF ANY DOUBT EXISTS, prehospital personnel shall initiate CPR unless the patient has a valid DNR order.

POLICY – AEMT II & PARAMEDIC PERSONNEL ONLY:

NOTE: BLS personnel and AEMT personnel not previously certified as an EMT II are not authorized to determine death based on the "Probable Death" criteria. They are limited to use of "Obviously Dead" criteria only.

PROBABLE DEATH: An AEMT II or paramedic may determine death, as follows, for individuals for whom "Obviously Dead" criteria do not apply. The absence of respiration, pulses, and neurological reflexes, in addition to one or more of the following, at the time of INITIAL assessment by the AEMT II or paramedic:

A. Lividity or 'Livor Mortis' (Lividity or Livor Mortis: Discoloration appearing on dependent parts of the body after death, as a result of cessation of circulation, stagnation of blood, and settling of the blood by gravity), and the monitor shows asystole in two (2) leads, or

B. The patient is a victim of cardiac arrest secondary to blunt or penetrating trauma, and the monitor shows asystole in two (2) leads, or

C. The patient is a victim of cardiac arrest secondary to blunt trauma, and the monitor shows PEA at a rate ≤ 40 beats per minute.

If there is any objection or disagreement by family members or prehospital personnel regarding terminating or withholding resuscitation, basic life support, including defibrillation, shall continue or begin immediately and EMS personnel shall contact the base/modified base hospital for further directions.

PROCEDURE – PROBABLE DEATH:

A. The assessments to confirm absence of respiration, pulse and neurological reflexes (and rigor mortis, if applicable) shall be performed and documented as defined on page 2, item C.

B. Probable death requires confirmation of Asystole in two (2) leads to confirm death. A minimum six-second rhythm strip of each lead shall be attached to the PCR.

C. Notify the county coroner or appropriate investigative authorities.

D. Document all relevant facts/findings, including approximate time of determination of death, in the PCR.

SPECIAL INFORMATION:

A. Hypothermia, drug and/or alcohol ingestion/overdose can mask the positive neurological reflexes which indicate life, so it is imperative to be certain no contributing environmental factors exist, such as cold water submersion or cold exposure. If any possibility exists that such conditions could be a factor, resuscitation should be started immediately.

B. In the event of a disaster/multi-casualty incident, death may be determined in accordance with START Triage criteria.

C. If a patient does not meet determination of death criteria on scene, once ambulance transport is started the base/modified base hospital on-line medical control can direct the paramedic to stop resuscitation efforts. When this occurs the ambulance will reduce transport code and continue transport to the destination hospital.

D. If a patient undergoing resuscitation is transported in a ground ambulance to rendezvous with an air ambulance and is determined dead by the flight nurse, the body shall not be moved from the rendezvous location. Notify the county coroner or appropriate investigative authorities.

CROSS REFERENCES:

Policy and Procedure Manual

Crime Scene Management, Reference No. 825

Do Not Resuscitate (DNR), Reference No 823

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 835

SUBJECT: MEDICAL CONTROL AT THE SCENE OF AN EMERGENCY

PURPOSE:

To define patient care responsibilities at the scene of a non-disaster medical emergency when two or more ALS/LALS personnel are present from two or more providers and to define the parameters for transferring patient care to another individual in the prehospital setting.

AUTHORITY:

California Health and Safety Code, Division 2.5, Sections 1797.220, 1798.6

California Code of Regulations, Title 22, Division 9

POLICY:

"Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any Paramedic, or other prehospital emergency personnel, at the scene of the emergency, who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency."

"Notwithstanding the above, authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks." (Health and Safety Code, Section 1798.6). Some limited examples are as follows:

HIGHWAY PATROL	*All freeways; all roadways in unincorporated areas to include right-of-way. (CVC 2454)*
SHERIFF'S OFFICE	*Off-highway unincorporated areas, i.e., parks, private property, etc. (Local policy)*

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LOCAL FIRE/POLICE	*Specific areas of authority within their jurisdiction, except freeways.*
AIRPORT/FIRE/POLICE	*Airports*
U.S. MILITARY	*National Defense Area; a military reservation or an area with "military reservation status" that is temporarily under military control, e.g., military aircraft crash site.*

PROCEDURE:

A. Medical management at the scene of a medical emergency includes:

1. Medical evaluation
2. Medical aspects of extrication and all movement of the patient(s)
3. Medical care
4. Patient destination, in consultation with base/modified base hospital when necessary
5. Mode of transport (ground or air)
6. Transport code

B. The first on duty ALS/LALS licensed and accredited or certified responder on the scene shall assume responsibility for the patient's care.

C. Whenever ALS/LALS personnel transfer patient care responsibility to another EMS provider, s/he is responsible for noting such action took place on the Patient Care Report (PCR). The responsible EMS personnel are required to document patient findings and treatments according to S-SV EMS Agency policy.

CROSS REFERENCES:

Policy and Procedure Manual

Prehospital Documentation, Reference No. 605

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

Multiple Casualty Incidents (MCI), Reference No. 837

Physician on Scene, Reference No. 839

Communication Failure, Reference No. 890

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 836

SUBJECT: HAZARDOUS MATERIALS INCIDENTS

PURPOSE:

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

AUTHORITY:

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

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

DEFINITIONS:

Hazardous Materials (Haz Mat) – Any material which is explosive, flammable, poisonous, corrosive, reactive, or radioactive, or any combination, and requires special care in handling because of the hazards it poses to public health, safety, and/or the environment.

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

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

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

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

Exclusion Zone (Hot Zone) - The contaminated area, Immediately Dangerous to Life and Health (IDLH).

Contamination Reduction Zone (Warm Zone) - The area where decontamination takes place.

Support Zone (Cold Zone) - The uncontaminated area where workers should not be exposed to hazardous conditions.

TRAINING AND COMPETENCY:

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

POLICY:

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

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

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

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

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

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

DISPATCH:

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

A. On scene wind direction and recommended approach route; coordinated with the IC

B. Staging Area location

C. Location of Incident Commander Post (if established)

D. Communication frequencies

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

F. Estimated number of patients

SCENE MANAGEMENT:

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

Observe wind and/or plume direction, if applicable.

Initial ambulance is first on scene:

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

1. First provide for your own safety

2. Isolate scene and deny entry (keep others away!). Move uninvolved victims to a safe zone

3. Notify dispatch and the base/modified base hospital that it is a Haz Mat scene. Ensure notification of local Haz Mat resources utilizing local procedures for hazardous materials incidents

4. Coordinate with other public safety personnel as they arrive on scene to establish the ICS

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

Initial ambulance – first responders already on scene:

A. If upon arrival of the first ambulance, the first responders have determined or have suspicion of a Haz Mat incident, ambulance providers will coordinate with other public safety personnel on scene to establish the ICS.

B. If the ICS has been established, ambulance personnel shall report to the IC or staging area manager upon arrival on scene.

Arrival at a known Haz Mat scene:

At no time shall EMS personnel enter the scene of a known Haz Mat incident without the clearance from the IC or designee. Once the Support Zone (Cold Zone) is established, the responding EMS unit(s) will stage as directed by the IC or designee. Once at scene, in coordination with the IC or designee, EMS will provide treatment and transport of patient(s) after decontamination is completed.

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

Recognition of a Haz Mat on-scene or during transport:

If EMS personnel become aware of hazardous materials while on scene or during transport:

A. Request Haz Mat response from appropriate jurisdictional authority.

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

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

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

PATIENT CARE:

A. EMS personnel shall not attempt to enter any Haz Mat scene or render medical care beyond the Support Zone (Cold Zone) without the specific direction from the IC or designee.

ONLY appropriately trained prehospital personnel utilizing appropriate Personnel Protective Equipment (PPE) shall perform treatment within the Exclusion (HOT) and Contamination Reduction (Warm) Zones.

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

C. For radiation contaminated patients that meet immediate triage criteria, treatment and transport will not be delayed for decontamination processes.

D. EMS personnel may only provide and/or initiate patient care after the patient has been transferred to them in the designated area as deemed by the IC or designee.

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

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

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

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

I. Treat as directed by specific S-SV EMS Agency protocol, and/or the base/modified base hospital. For specific treatments see S-SV EMS Agency protocols as follows:

1. Chemical burns, Organophosphate or Carbamate pesticides, and Hydrofluoric Acid see Hazardous Material Exposure Protocol, Reference No. E-7.

2. Nerve Agent Exposure see Nerve Agent Treatment Protocol, Reference No. E-8.

CROSS REFERENCES

Policy and Procedure Manual

Ingestions and Overdoses, Reference No. M-5

Hazardous Material Exposure, Reference No. E-7

Nerve Agent Treatment, Reference No. E-8

Emergency Response Guidebook (ERG)

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 839

SUBJECT: PHYSICIAN ON SCENE

PURPOSE:

To define patient care responsibilities when a physician is on the scene of a medical emergency, and one or more EMS personnel are present.

AUTHORITY:

California Health and Safety Code, Division 2.5, Section 1797.220, 1798.2

California Code of Regulations, Title 22, Division 9

POLICY:

It is the policy of the S-SV EMS Agency that EMS personnel encountering a physician on the scene shall maintain responsibility for patient care unless the physician assumes responsibility for patient care and accompanies the patient to the hospital (if safety allows).

EMS personnel may assist the physician provided they operate within the approved S-SV EMS Agency scope of practice.

PROCEDURE:

A. Physician is a bystander:

1. Take care of patient first.

2. Require I.D., if needed, use the EMS/CMA Physician On Scene Card included in this policy.

3. If the physician wishes to do more than offer assistance, they must get approval from the base/modified base hospital.

4. If there is a conflict between the physician's requested treatment and the EMS personnel's scope of practice, explain that you can legally only treat within the S-SV EMS Agency's scope of practice. Contact medical control and ask the physician to discuss any issues with the base/modified base hospital.

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5. The physician must:

    a. Assume responsibility for the patient

    b. Provide the care s/he wishes

    c. Accompany the patient to the hospital (if safety allows)

6. In the event of conflict, follow orders of medical control and document events.

B. Physician is patient's physician:

1. Require I.D. if physician is unknown to EMS personnel.

2. The patient's physician may administer medication from his/her drug inventory.

3. If there is a conflict between patient's physician's orders and the EMS personnel's scope of practice, explain that you can legally only treat within the S-SV EMS Agency's scope of practice. Contact medical control and ask patient's physician to discuss any problem issues with the base/modified base hospital.

4. In the event of conflict, follow orders of medical control and document events.

CROSS REFERENCES:

Policy and Procedure Manual

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

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803.

SUBJECT: PHYSICIAN ON SCENE

EMSA/CMA PHYSCIAN ON SCENE CARD:

FRONT

cma
CALIFORNIA MEDICAL ASSOCIATION

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMS PERSONNEL

EMS personnel operate under standard policies and procedures developed by the Local EMS Agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority and CCLHO.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code" (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104). **(over)**

BACK

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose one of the following:

1. **Offer your assistance with another pair of eyes, hands or suggestions, but let EMS personnel remain under base hospital control; or,**
2. **Request to talk to the base station physician and directly offer your medical advice and assistance; or,**
3. **Take total responsibility for the care given by EMS personnel and physically accompany the patient until the patient arrives at a hospital (if safety allows) and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician)**

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 848

SUBJECT: CANCELLATION OR REDUCTION OF ALS/LALS RESPONSE

PURPOSE:

To identify the responsibilities of BLS prehospital personnel when canceling/reducing responding ALS/LALS resources after patient contact has been made.

AUTHORITY:

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

California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 100147, 100169 and 100170

DEFINITIONS:

A. **Code 4 or Canceled Call** - is defined as no further assistance is needed by the Incident Commander (IC) or designee. Further responding units are canceled. All ALS/LALS units dispatched via the 911 system that are canceled prior to arrival on scene shall be considered to be Code 4.

B. **No Patient Contact** - is defined as arrival at scene and unable to locate any patient. Verbal or physical contact with a patient has not been made.

C. **Code 3** - is defined as proceeding with red lights and siren, according to the California Vehicle Code.

D. **Code 2** - is defined as proceeding expeditiously but obeying all traffic laws without exception.

E. **Competent Person** – is a person with a capacity to understand the nature of his/her medical condition, and not impaired by alcohol, drugs or medications, mental illness, traumatic injury, grave disability or mental abilities diminished because of age.

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SUBJECT: CANCELLATION OR REDUCTION OF ALS/LALS RESPONSE

POLICY:

A. Cancellation of Responding Units:

1. The IC or designee on the scene of an incident may cancel a responding ALS/LALS resource upon determination of the following:

   a. That the incident does not involve an injury or illness which would require assessment, treatment or transport by Paramedic or Advanced EMT personnel; or,

   b. When the patient is a competent adult and is refusing ALS/LALS assessment and or transport.

2. Before canceling the ALS/LALS resource, consider the medicolegal responsibility involved.

3. Once an ALS/LALS unit has arrived on scene, and ALS/LALS personnel are within visual range of the patient, the ALS/LALS personnel should attempt to make patient contact.

B. Reducing Code of Responding Units:

The IC or designee on the scene of a medical incident may reduce a responding ALS/LALS resource from Code 3 to Code 2 upon determination that, in the best judgment of the IC or designee, the illness or injury is not immediately life-threatening and that the difference in Code 3 and Code 2 response time would not likely have an impact on patient safety.

Note: When an ambulance is reduced to Code 2, it is possible that the responding ambulance will be redirected to a different Code 3 call, resulting in a delayed ambulance response.

C. Incidents when the ALS/LALS resource should not be canceled by BLS personnel:

1. Medical:

   a. Cardiac arrest with active CPR
   b. Cardiac symptoms
   c. Difficulty breathing
   d. Altered mental status
   e. Drug ingestion
   f. Seizures
   g. Near drowning
   h. Hemorrhage
   i. All Pediatric patients < 3 years old

2. Patients who meet Trauma Triage Criteria as defined in S-SV EMS Agency Trauma Triage Criteria Policy, Reference No. 860

CROSS REFERENCES:

Policy and Procedure Manual

Patient Initiated Released at Scene (RAS) or Patient Initiated Refusal of Service (AMA), Reference No. 850

Treatment/Transport of Minors, Reference No. 851

Trauma Triage Criteria, Reference No. 860

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 852

SUBJECT: VIOLENT PATIENT RESTRAINT MECHANISMS

PURPOSE:

To provide guidelines on the use of restraint mechanisms in the field or during transport for patients who are violent, potentially violent, or who may harm themselves or others.

AUTHORITY:

California Code of Regulations, Title 22

Welfare and Institutions Code, 5150

Health and Safety Code, Division 2.5, Sections 1797.202, 1797.220, 1798.

PRINCIPLES:

A. The safety of the patient, community, and responding personnel is of paramount concern when following this policy.

B. Restraint mechanisms are to be used only when necessary in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others.

C. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, hypoxia, alcohol, drug related problems, hypoglycemia and other metabolic disorders, stress and psychiatric disorders.

D. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise vascular or neurological status.

E. Restraints applied by law enforcement require the officer to remain available at the scene or during transport to remove or adjust the restraints for patient safety.

F. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene management control.

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POLICY:

A. The base/modified base hospital shall be informed as soon as possible with the time and reason of the decision to restrain.

B. Monitor vital signs.

C. Be prepared to provide airway/ventilation management.

D. Patients shall not be transported in a prone position. Prehospital personnel must ensure that the patient's position does not compromise their respiratory/circulatory systems, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

E. Forms of Restraint:

1. Physical Restraint:

a. Restraint devices applied by prehospital personnel must be padded soft restraints that will allow for quick release.

b. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and every 10 minutes thereafter. It is recognized that the evaluation of vascular and neurological status requires patient cooperation, and thus may be difficult or impossible to monitor.

c. Restraints shall be applied in such a manner that they do not cause vascular, neurological or respiratory compromise. Any abnormal findings require the restraints to be removed and reapplied or supporting documentation as to why restraints could not be removed and reapplied.

d. The following forms of restraint shall NOT be applied by EMS prehospital care personnel:

- Hard plastic ties or any restraint device requiring a key to remove. EXCEPTION: see Section G: Interfacility Transport of Psychiatric Patients.

- Restraining a patient’s hands and feet behind the patient.

- “Sandwich” restraints, using backboard, scoop-stretcher or flats.

e. Restraints shall not be attached to movable side rails of a gurney.

2. Chemical Restraint

   If a patient remains combative despite physical restraint, such that further harm to the patient or provider(s) is possible:

> **Midazolam:**
>
> - **IV/IO – 0.1 mg/kg (max dose 4 mg)**
> - **IM/IN – 0.2 mg/kg (max dose 8 mg)**

F. In situations where the patient is in custody and/or under arrest and handcuffs or other restraint devices have been applied by law enforcement officers:

   1. Restraint devices applied by law enforcement must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.

   2. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer should accompany the patient in the ambulance. In the unusual event that this is not possible, the officer should follow by driving in tandem with the ambulance on a pre-determined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene. Patients in custody/arrest remain the responsibility of law enforcement.

G. Interfacility Transport of Psychiatric Patients

   1. A two-point, locking, padded cuff and belt restraint and/or two-point locking, padded ankle restraints may be used only in the interfacility transport of psychiatric patients on a 5150 hold.

   2. Transport personnel must be provided with a written restraint order from the transferring physician or their designee as part of the transfer record.

   3. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and every 10 minutes thereafter. Any abnormal findings require the restraints to be removed and reapplied or supporting documentation as to why restraints could not be removed and reapplied.

   4. Transport personnel shall have immediate access to the restraint key at all times during the transport.

H. Required documentation on the Patient Care Report (PCR)

1. Type of restraint mechanisms utilized.
2. Reason restraint mechanism utilized.
3. Identity of agency/medical facility applying physical restraints.
4. Assessment of the vascular and neurological status of the restrained extremities.
5. Assessment of the cardiac and respiratory status of the restrained patient.

CROSS REFERENCE:

Policy and Procedure Manual

Patient Destination, Reference No. 505

ALS Inventory, Reference No. 701

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

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

Tasered Patients Care & Transport, Reference No. 853

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 853

SUBJECT: TASERED PATIENTS CARE AND TRANSPORT

PURPOSE:

To establish guidelines for EMS personnel in the treatment and transportation of patients on whom a TASER has been used.

AUTHORITY:

California Code of Regulations, Title 22, Section 100169

Health & Safety Code, Sections 1797.204, 1797.220, 1798

GENERAL CONSIDERATIONS:

A. A TASER is designed to transmit electrical impulses that temporarily disrupt the body's nervous system. Its Electro-Muscular Disruption (EMD) technology causes an uncontrollable contraction of the muscle tissue, allowing the TASER to physically debilitate a target regardless of pain tolerance or mental focus.

B. The scene must be safe and secured by law enforcement before EMS personnel will evaluate or treat the patient.

C. Assess the patient for any potential cause of the abnormal or combative behavior such as, but not limited to, head trauma, hypoxia, drug and alcohol related problems, hypoglycemia and other metabolic disorders, stress and psychiatric disorders and treat according to the appropriate protocol.

D. Assess the patient for any potential injury after the TASER was deployed. Remember the TASER will cause the patient to fall to the ground or become incapacitated.

POLICY:

A. TASER probes should not be removed by EMS personnel unless they interfere with the treatment or safe transportation of the patient. Only EMT, Advanced EMT and Paramedic personnel are approved to remove TASER probes in the prehospital setting. TASER probes should be considered legal evidence and if removed shall be offered to law enforcement prior to disposal. Follow law enforcement direction regarding the preservation or disposal of TASER probes.

B. Mode of transportation and destination to be determined by law enforcement, in consultation with EMS personnel and/or the base/modified base hospital if necessary.

PROCEDURE:

A. When safe to do so, patients should be immediately evaluated, with particular attention to signs and symptoms of excited delirium.

B. Any injuries or medical conditions will be treated according to the appropriate treatment protocol.

C. These patients will be in custody of law enforcement and will require transportation to an emergency department for medical clearance.

D. If EMS personnel determine that the patient is a danger to themself or others, law enforcement officer(s) may be requested to accompany the patient.

E. Unless otherwise contraindicated, the patient should be adequately and safely restrained.

F. If one or both of the TASER probes requires removal:

1. Verify the wires to the probes have been severed.

2. Use routine biohazard precautions.

3. Place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. Keep your hand away from the probe. With your other hand, in one fluid motion pull the probe straight out from the puncture site.

4. Follow law enforcement direction regarding the preservation or disposal of TASER probes.

5. Apply direct pressure for bleeding, and apply a sterile dressing to the wound site.

DOCUMENTATION

The following must be documented on the PCR

A. The patient's presenting behavior or signs/symptoms which lead law enforcement to tase the patient, if available.

B. Baseline patient assessment including, but not limited to, oxygen saturation, blood glucose level, neurological assessment, vital signs. Repeat assessment every 10 minutes until arrival at the ED.

C. Time of TASER barb removal, if applicable.

D. Anatomic location of the TASER barb(s).

E. Whether or not the TASER barb(s) are intact following removal.

CROSS REFERENCES:

Policy and Procedure Manual

Patient Destination, Reference No. 505

Trauma Triage Criteria, Reference No. 860

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

Violent Patient Restraint Mechanisms, Reference No. 852

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SIERRA SACRAMENTO VALLEY EMS AGENCY

TREATMENT PROTOCOL – MEDICAL EMERGENCY

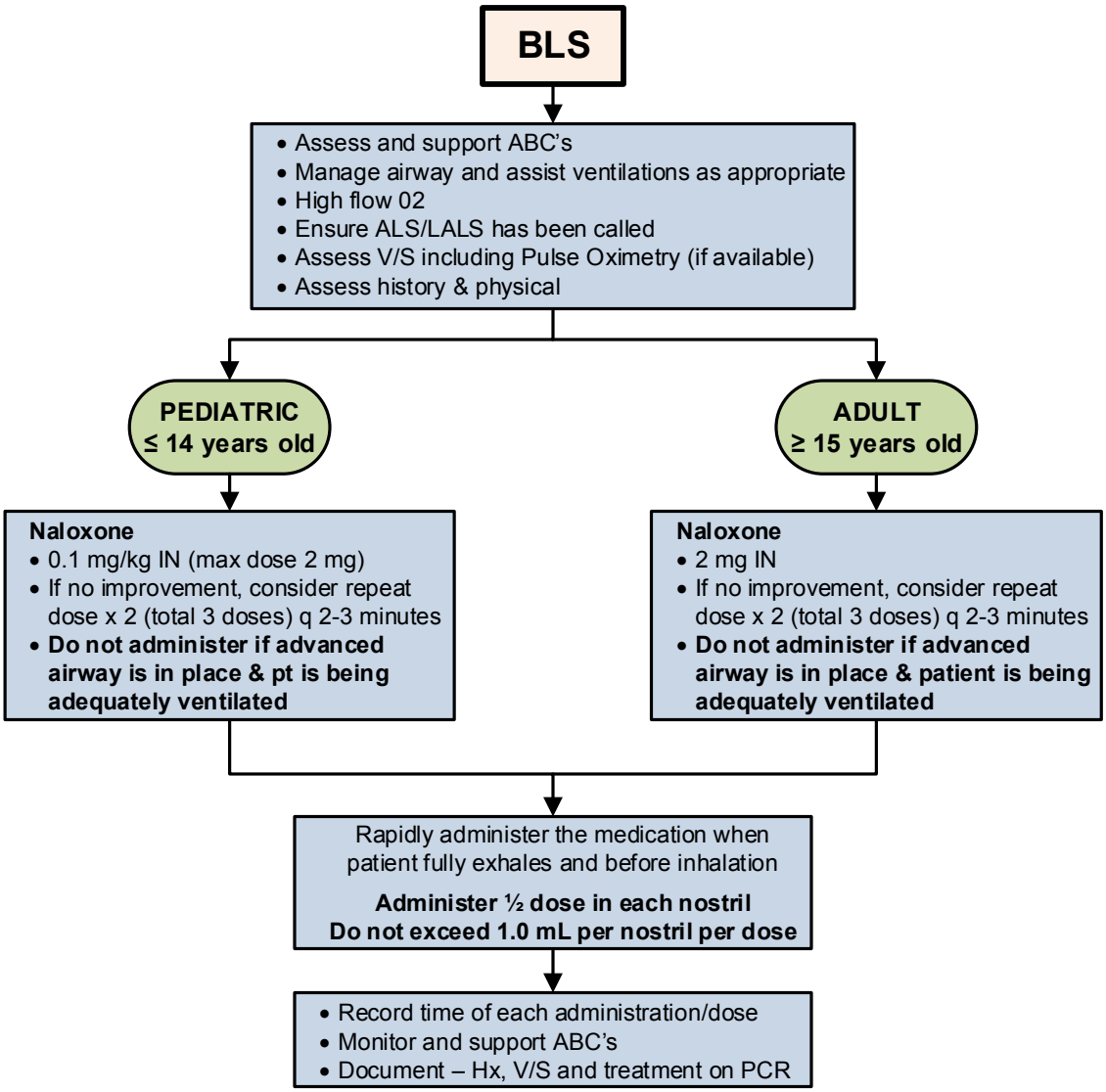
EMT OPTIONAL SKILL

REFERENCE NO. 873

SUBJECT: EMT ADMINISTRATION OF INTRANASAL NALOXONE FOR SUSPECTED NARCOTIC OVERDOSE WITH RESPIRATORY DEPRESSION

Candidates for intranasal (IN) administration of naloxone by optional skill(s) accredited EMTs are:

- **Adult and pediatric patients with suspected narcotic overdose and respiratory depression only. Patients must meet both of the following criteria to be eligible for IN naloxone administration:**
  - **Unconscious**
  - **Respiratory depression defined as a respiratory rate < 12 or inadequate respiratory efforts**



Effective Date: 12/01/2013
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Approved by:

Date last reviewed revised: 07/13

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 877

SUBJECT: EMT ESOPHAGEAL TRACHEAL AIRWAY DEVICE (ETAD) TREATMENT GUIDELINES

PURPOSE:

To define the specific conditions under which S-SV accredited EMT personnel may utilize an Esophageal Tracheal Airway Device (ETAD).

AUTHORITY:

California Health & Safety Code, Division 2.5, Section 1797.80, 1797.90, 1797.170, 1797.177, 1797.220, 1798.22 and 1798.104

California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100064

POLICY:

A. Indications for Insertion:

ALL must be present

1. Unconscious/no purposeful response
2. Absent gag reflex
3. Apnea or respiratory rate ≤ 6/min
4. Appears at least 4 feet tall (37 Fr device), or at least 5 feet tall (41 Fr device)

B. Ventilate/oxygenate the patient for at least 1-2 minutes before attempting insertion.

C. Cautions:

1. Insertion attempts may not take more than 30 seconds
2. Do not use excessive force

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SUBJECT: EMT ESOPHAGEAL TRACHEAL AIRWAY DEVICE (ETAD) TREATMENT GUIDELINES

DOCUMENTATION:

Document time of placement and results of tube placement checks performed throughout the resuscitation and transport.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Optional Skill(s) Base/Modified Base Hospital Medical Control Requirements, Reference No. 377

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

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

EMT Optional Skill(s) Personnel Requirements for Accreditation, Reference No. 977

Advanced Airway Management, Reference No. 1104

SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 890

SUBJECT: COMMUNICATION FAILURE

PURPOSE

To define the specific conditions under which a paramedic or Advanced EMT may utilize Advanced Life Support (ALS) medications 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/modified base hospital but cannot establish or maintain that contact:

A. The paramedic or Advanced EMT may initiate necessary ALS procedures specified in approved S-SV EMS Agency policies and protocols.

B. Procedures and/or medications listed as **"Base/Modified Base Hospital Order Only"** may still be performed in the event of communication failure if warranted by the patient condition.

C. The following procedures and/or medications listed as "**"Base/Modified Base Hospital Physician Order Only" shall not** be performed/administered in the event of a communication failure and without a direct order from a base/modified base hospital physician:

1. Terminating resuscitative efforts utilizing the BLS termination of resuscitation criteria if no ROSC in an adult pulseless arrest patient (Reference No. C-1)

2. Administration of activated charcoal (Reference No. M-5)

3. Activation and utilization of the Nerve Agent Treatment Protocol (Reference No. E-8)

SUBJECT: COMMUNICATION FAILURE

PROCEDURE

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

A. Attempt to establish base/modified base hospital contact by telephone and/or radio throughout the call as circumstances permit.

B. Immediately upon voice contact, provide a verbal report to the base/modified base hospital physician or MICN.

C. Document the existence and reason for the communication failure in the PCR.

CROSS REFERENCES:

Policy and Procedure Manual

Modified Base Hospital, Reference No. 305

Base/Modified Base/Receiving 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

CERTIFICATION/RECERTIFICATION
REFERENCE NO. IX

SUBJECT: INDEX REFERENCE NO. 900

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 977

SUBJECT: EMT OPTIONAL SKILL(S) PERSONNEL REQUIREMENTS FOR ACCREDITATION

PURPOSE:

To establish the initial and ongoing EMT optional skill(s) personnel requirements for accreditation. The EMT optional skills available in the S-SV EMS region are:

A. Utilization of perilaryngeal airway adjuncts:

1. Esophageal-tracheal airway device (ETAD)

2. King LT Airway device

B. Administration of intranasal naloxone for suspected narcotic overdose with respiratory depression.

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

D. Administration of atropine and pralidoxime chloride by auto-injector (Mark-I/DuoDote Kit) for nerve agent exposure.

AUTHORITY:

California Health and Safety Code, Division 2.5, Section 1797.80, 1797.90, 1797.170, 1797.177, 1797.220, 1798.2 and 1798.104

California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100064

POLICY:

EMT personnel shall fulfill all accreditation eligibility requirements prior to utilizing any approved EMT optional skill(s). Optional skill(s) accredited EMT personnel shall maintain accreditation, as defined in this policy. Optional skill(s) accredited EMT personnel shall only utilize approved optional skills when legally working for and on duty with an S-SV EMS Agency approved EMT optional skill(s) service provider (including mutual aid responses).

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A. Initial Accreditation Process:

In order to be eligible for initial accreditation, an individual shall meet/complete all of the following:

1. Affiliation with an S-SV EMS Agency approved EMT optional skill(s) service provider.

2. Current and valid California EMT certification.

3. Current CPR certification which is taught to the curriculum standards of the American Heart Association, American Red Cross or the National Safety Council at the Health Care Provider or equivalent level.

4. Successful completion of an S-SV EMS Agency approved EMT optional skill(s) training program including all required written and skills examinations.

B. Maintaining Accreditation:

An authorized individual shall meet/complete all of the following requirements on an ongoing basis:

1. Maintain affiliation with an S-SV EMS Agency approved EMT optional skill(s) service provider.

2. Maintain California EMT certification.

3. Maintain CPR certification which is taught to the curriculum standards of the American Heart Association, American Red Cross or the National Safety Council at the Health Care Provider or equivalent level.

4. Maintain biannual skill(s) competency verification requirements provided by the S-SV EMS Agency approved EMT optional skill(s) service provider.

C. Accreditation Action:

1. An accredited EMT who fails to maintain any of the S-SV EMS Agency accreditation requirements listed in this policy shall not utilize the optional skill(s) until all accreditation requirements are met.

2. An EMT who fails to demonstrate competency of an EMT optional skill may have his/her EMT optional skill(s) accreditation denied, suspended, revoked or placed on probation.

In such instances, all procedures and processes included in S-SV EMS policy 'EMT/AEMT Denial of Certification/Accreditation, Incident Investigation, Determination of Actions, Notification and Administrative Hearing Process', Reference No. 903 will be followed.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Optional Skill(s) Base/Modified Base Hospital Medical Control Requirements, Reference No. 377

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

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

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

EMT Administration of Intranasal Naloxone for Suspected Narcotic Overdose With Respiratory Depression, Reference No. 873

EMT Esophageal Tracheal Airway Device Treatment Guidelines, Reference No. 877
Nerve Agent Treatment, Reference No. E-8

EMT/AEMT Denial of Certification/Accreditation, Incident Investigation, Determination of Actions, Notification and Administrative Hearing Process', Reference No. 903

King Airway, Reference No. 1102

Advanced Airway Management, Reference No. 1104

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SIERRA-SACRAMENTO VALLEY EMS AGENCY

PROCEDURE POLICIES
SECTION XI

SUBJECT: INDEX **REFERENCE NO. 1100**

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 1102

SUBJECT: KING AIRWAY

PURPOSE:

To define the indications and use of the King Airway in the prehospital setting by paramedic, Advanced EMT and approved EMT personnel.

AUTHORITY:

Health and Safety Code 1797.220 and 1798

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

POLICY:

Paramedic, Advanced EMT and approved EMT personnel may use the King Airway as an option for advanced airway management.

PROCEDURE:

A. **Indications**: Patients who require assisted ventilation and meet criteria for an advanced airway:

1. Cardiac arrest.

2. Respiratory arrest or severe compromise AND unable to adequately ventilate with BVM.

3. May be used as a primary airway or after one or more unsuccessful endotracheal intubation attempts.

B. The following contraindications shall be observed:

1. Conscious patients with a gag reflex.

2. Patients under four (4) feet tall.

3. Known cases of esophageal diseases, suspected ingestion of caustic substances or extensive airway burns.

4. Laryngectomy with stoma.

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C. Placement:

1. Select appropriate sized King Airway:

    a. Size 3 – Patient between 4 and 5 feet tall (55 ml air)
    b. Size 4 – Patient between 5 and 6 feet tall (70 ml air)
    c. Size 5 – Patient over 6 feet tall (80 ml air)

2. Check King Airway cuffs to ensure patency. Deflate tube cuffs. Leave syringe attached. Lubricate the tip of the tube with water soluble lubricant.

3. Oxygenate with 100% oxygen.

4. Position the head. The ideal position is the "sniffing position". A neutral position can also be used if trauma is suspected.

5. Hold the King Tube at the connector with the dominate hand.

6. With non-dominate hand, hold mouth open and apply chin lift.

7. Using a lateral approach, introduce tip into mouth.

8. Advance the tip behind the base of the tongue while rotating tube back to midline so that the blue orientation line faces the chin of the patient.

9. Without exerting excessive force, advance tube until base of connector is aligned with teeth or gums.

10. Inflate cuffs based on size according to Section 1 above.

11. Attach bag-valve to King Airway. While gently bagging the patient to assess ventilation, withdraw the airway until ventilation is easy and free flowing.

12. Attach bag valve device and verify placement by **ALL** of the following:

    a. Rise and fall of the chest
    b. Bilateral breath sounds
    c. Absent epigastric sounds
    d. CO2 measurement (waveform capnography, capnometer, or colorimetric device)

13. If there is any question about the proper placement of the King Airway, deflate the cuffs and remove the device, ventilate the patient with a BVM for 30 seconds and repeat.

14. Secure the tube with tape or commercial tube holder. Note depth marking on tube.

15. Continue to monitor the patient for propter tube placement throughout prehospital treatment and transport.

D. Troubleshooting:

1. If placement is unsuccessful, remove tube, ventilate via BVM and repeat the sequence of steps.

2. If unsuccessful on second attempt, BLS airway management should be resumed.

3. Most unsuccessful placements relate to failure to keep tube in midline during placement.

E. Additional Information:

1. Cuffs can be lacerated by broken teeth or dentures. Remove dentures before placing tube.

2. Do not force tube, as airway trauma can occur.

F. Documentation:

Document time of placement and results of tube placement checks performed throughout the resuscitation and transport.

CROSS REFERENCES:

Policy and Procedure Manual

EMT Scope of Practice, Reference No. 801

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

Pulseless Arrest, Reference No. C-1

Airway Obstruction, Reference No. R-1

Respiratory Arrest, Reference No. R-2

Shock/Non-Traumatic Hypovolemia, Reference No. M-2

Ingestions and Overdoses, Reference No. M-5

Altered Level of Consciousness. Reference No. N-1

General Trauma Management, Reference No. T-1

Burns: Thermal & Electrical, Reference No. T-10

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 1103

SUBJECT: MUCOSAL ATOMIZATION DEVICE

PURPOSE:

To define the indications and use of the Mucosal Atomization Device (MAD) in the prehospital setting by EMS personnel.

AUTHORITY:

Health and Safety Code 1797.220 and 1798

California Code of Regulations, Title 22, Division 9

OVERVIEW:

In the absence of an established IV, intranasal is a rapid route offering a high level of bio-availability of the medication being administered. The intranasal route can reduce the risk of needlesticks while delivering effective medication levels.

The rich vasculature of the nasal cavity provides a direct route into the bloodstream for medications that easily cross the mucous membranes. Due to this direct absorption into the bloodstream, rate and extent of absorption are relatively comparable to IV administration.

INDICATIONS:

EMS personnel may utilize the Mucosal Atomization Device (MAD) as an alternative drug delivery adjunct for patients without IV access who require urgent medication administration.

MEDICATIONS THAT MAY BE ADMINISTERED VIA INTRANASAL (IN) ROUTE:

A. Fentanyl

B. Glucagon

C. Naloxone (Narcan)

D. Midazolam (Versed)

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SUBJECT: MUCOSAL ATOMIZATION DEVICE (MAD)

PROCEDURE:

A. Determine appropriate medication dose per applicable protocol.

B. Draw up medication into a syringe using appropriate transfer needle.

C. Purge air from syringe.

D. Place mucosal atomization device on the end of the syringe and screw into place.

E. Gently insert the atomizer into the nare. Stop once resistance is met.

F. Rapidly administer the medication when patient fully exhales and before inhalation. **ADMINISTER ½ DOSE IN EACH NOSTRIL.**

G. Do not exceed 1.0 ml per nostril.

H. Evaluate the effectiveness of the medication, if desired effect has not been achieved, consider repeating and/or changing route of administration.

CONTRAINDICATIONS:

A. Epistaxis.

B. Nasal Trauma.

C. Nasal Septal Abnormalities.

D. Nasal Congestion/Discharge.

PRECAUTIONS:

A. Nasal administration does not always work for every patient.

B. Nasal administration is less likely to be effective if the patient has been abusing inhaled vasoconstrictors such as cocaine.

CROSS REFERENCES:

Policy and Procedure Manual

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

Restraint of Violent Patients, Reference No. 852

EMT Administration of Intranasal Naloxone for Suspected Narcotic Overdose with Respiratory Depression, Reference No. 873

Tachycardia with Pulses, Reference No. C-6

Bradycardia, Reference No. C-7

Respiratory Arrest, Reference No. R-2

Ingestions and Overdoses, Reference No. M-5

General Medical Treatment Protocol, Reference No. M-6

Altered Level of Consciousness, Reference No. N-1

Seizure, Reference No. N-2

Cold Stress Emergencies, Reference No. E-2

Frostbite, Reference No. E-3

Hazardous Materials Exposure, Reference No. E-7

Isolated Extremity Injury – Including Hip or Shoulder Injuries, Reference No. T-6

Burns: Thermal & Electrical, Reference No. T-10

Pediatric Respiratory Arrest, Reference No. P-12

Pediatric Overdose and/or Poisoning, Reference No. P-22

Pediatric Altered Level of Consciousness, Reference No. P-24

Pediatric Seizure, Reference No. P-26

Pediatric Burns: Thermal & Electrical, Reference No. P-28

Pediatric Isolated Extremity Injury – Including Hip or Shoulder Injuries, Reference No. P-30

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SIERRA-SACRAMENTO VALLEY EMS AGENCY
PROGRAM POLICY

REFERENCE NO. 1104

SUBJECT: ADVANCED AIRWAY MANAGEMENT

PURPOSE:

To establish minimum guidelines, procedures and requirements for the use of advanced airway procedures in critical patients in the S-SV EMS region.

AUTHORITY:

Health and Safety Code 1797.220 and 1798

California Code of Regulations, Title 22, Division 9

POLICY:

A. The S-SV EMS Agency approved advanced airway management procedures for adult patients consist of the following:

1. Endotracheal Intubation

2. Nasotracheal Intubation

3. Insertion of an esophageal-tracheal double-lumen airway (ETDLA)

4. Insertion of a King Airway device

B. The preferred method of airway management for the pediatric patient ≤ 14 years of age is Bag-Valve-Mask (BVM) ventilation. Intubation in this age group should be performed **only** if BVM is unsuccessful or impossible (see General Pediatric Protocol, Reference No. P-1)

C. Paramedic personnel are authorized to perform any of the advanced airway skills listed in this policy.

D. Advanced EMT (AEMT) personnel are authorized to perform the skill of insertion of an ETDLA or King Airway device only. AEMT personnel may not intubate.

E. EMT personnel are authorized to perform the skill of insertion of an ETDLA or King Airway device **only** if their provider has been authorized by the S-SV EMS Agency as an approved EMT Optional Skill(s) service provider and they have

successfully completed an approved training program. EMT personnel may not intubate.

F. Defer advanced airway insertion rather than interrupt chest compressions in the cardiac arrest patient.

G. EMS personnel must confirm correct advanced airway placement with physical assessment (auscultation, observation of chest rise, visualization of the tube passing through the cords, etc.) in addition to one or more of the following methods:

1. Waveform Capnography (Preferred)

2. Esophageal Detection Device (EDD) **and** Capnometer

3. Esophageal Detection Device (EDD) **and** Colorimetric end-tidal CO_2 detector device

H. Paramedic/AEMT personnel must re-confirm correct advanced airway placement utilizing the methods listed above on any patient where the airway has been established by an EMT Optional Skill(s) provider. Paramedic/AEMT personnel assume responsibility for the advanced airway once they have arrived on scene and established patient care.

I. A paramedic or AEMT who establishes an advanced airway shall accompany the patient to the hospital if the patient is transported. This does not apply to multiple patient incidents or when patient care is appropriately transferred to another ALS provider (EMS Aircraft, etc.). In these cases, the receiving ALS provider must re-confirm correct advanced airway placement immediately upon transfer of patient care.

J. Advanced airway placement must be re-confirmed by the EMS personnel utilizing the methods listed above, any time there is concern about the patency of the airway or any time there is a movement of the patient; including but not limited to:

1. Movement of the patient onto the ambulance gurney

2. Movement of the patient into or out of the ambulance

3. Movement of the patient from the ambulance gurney to the hospital gurney when able.

If the advanced airway is determined to no longer be patent during a re-confirmation assessment, appropriate measures must be immediately taken to re-establish the patency of the airway. This may include removal of the advanced airway and the utilization of BLS airway measures until the advanced airway can

be appropriately re-established. EMS personnel shall confirm that the advanced airway remains patent when the patient is transferred from the ambulance gurney to the hospital gurney and any concerns must be reported immediately to the receiving ED physician.

PROCEDURE:

A. Indications:

Patients who require assisted ventilation and meet the following criteria:

1. Cardiac arrest

2. Respiratory arrest or severe compromise and unable to adequately ventilate with BVM

B. Endotracheal Intubation – (paramedic personnel only):

1. An intubation attempt is defined as the introduction of an endotracheal tube past the patient's teeth.

2. Make no more than 2 total attempts per patient at placing the endotracheal tube. Each attempt should not last longer than 30 seconds. Ventilate with 100% oxygen for a minimum of one minute prior to each attempt. If endotracheal intubation is unsuccessful; an ETDLA or King Airway Device shall be utilized if an advanced airway remains necessary.

3. Pediatric intubation should be performed only if BVM ventilation is unsuccessful or impossible (General Pediatric Protocol, Reference No. P-1)

C. Esophageal-Tracheal Double-Lumen Airway (ETDLA) Device (Combitube®) or King Airway Device:

1. An ETDLA or King Airway device may be placed as a primary airway or after unsuccessful attempt(s) at endotracheal intubation

2. The ETDLA comes in two sizes:

   a. Small Adult 37 fr. – Patient between 4 and 5 feet tall
   b. Adult 41 fr. – Patient over 5 feet tall

3. The King Airway comes in three sizes:

   a. Size 3 – Patient between 4 and 5 feet tall
   b. Size 4 – Patient between 5 and 6 feet tall
   c. Size 5 – Patient over 6 feet tall

4. The ETDLA and King Airway devices are not to be used in patients < 4 feet tall.

D. Confirm Advanced Airway Placement:

1. If waveform capnography is not available, use an approved bulb-type esophageal detection device (EDD) prior to ventilating through the tube. Squeeze the bulb, apply to end of tube, and release the bulb. If the tube properly placed, the bulb should fully inflate in ≤ 5 seconds. Remove the bulb and begin ventilation.

2. Auscultate both lung fields for breath sounds, confirm chest rise with ventilation. Listen over left upper quadrant of the abdomen for air in the stomach.

3. Attach an approved end-tidal CO_2 detector (colorimetric device), capnometer or waveform capnography unit, that must remain in place until arrival at the hospital, Waveform Capnography is preferred and must be used if available.

4. All devices used to confirm advanced airway placement must be documented in the PCR (EDD, $ETCO_2$ – colorimetric or capnography).

5. If there is any doubt as to the proper placement of the endotracheal tube, visualize the pharynx and vocal cords with laryngoscope and use capnography. If still in doubt, suction the patient, deflate the cuff and remove the endotracheal tube.

E. If the patient regains consciousness while intubated, do not extubate. Use restraints as necessary to prevent uncontrolled extubation and consider sedation as follows:

Midazolam:

- **IV/IO – 0.1 mg/kg (max dose 4 mg)**
- **IM/IN – 0.2 mg/kg (max dose 8 mg)**

QI DOCUMENTATION TRACKING:

A. An S-SV EMS Agency Regional QI Tracking Form (Reference No. 620-A) shall be completed and submitted to the S-SV EMS Agency for any utilization of the following Paramedic Optional Scope of Practice advanced airway procedures:

1. Nasotracheal Intubation

2. Pediatric Intubation

SUBJECT: ADVANCED AIRWAY MANAGEMENT

CROSS REFERENCES:

Policy and Procedure Manual

S-SV EMS Agency Regional QI Tracking Form (Reference No. 620-A)

EMT Scope of Practice, Reference No. 801

Advanced EMT Scope of Practice, Reference No. 802

Paramedic Scope of Practice, Reference No. 803

EMT Esophageal Tracheal Airway Device (ETAD) Treatment Guidelines, Reference No. 877)

Pulseless Arrest, Reference No. C-1

Airway Obstruction, Reference No. R-1

Respiratory Arrest, Reference No. R-2

Shock/Non-Traumatic Hypovolemia, Reference No. M-2

Ingestions and Overdoses, Reference No. M-5

Altered Level of Consciousness. Reference No. N-1

General Trauma Management, Reference No. T-1

Burns: Thermal & Electrical, Reference No. T-10

General Pediatric Protocol, Reference No. P-1

King Airway Device, Reference No. 1102